Wiltshire Council
Where everybody matters

AGENDA

Meeting: Health Select Committee

Place: Council Chamber - County Hall, Trowbridge BA14 8JN

Date: Tuesday 23 September 2014

Time: **10.30 am**

Please direct any enquiries on this Agenda to Adam Brown, of Democratic Services, County Hall, Bythesea Road, Trowbridge, direct line (01225) 718038 or email adam.brown@wiltshire.gov.uk

Press enquiries to Communications on direct lines (01225) 713114/713115.

This Agenda and all the documents referred to within it are available on the Council's website at www.wiltshire.gov.uk

Membership:

Cllr Chris Caswill
Cllr Mary Champion
Cllr Christine Crisp (Chair)
Cllr Mary Douglas
Cllr Bob Jones MBE
Cllr Gordon King
Cllr John Knight
Cllr Dr Helena McKeown
Cllr John Noeken (Vice Chairman)
Cllr Jeff Osborn
Cllr Nina Phillips
Cllr Pip Ridout
Cllr John Walsh

Substitutes:

Cllr Pat Aves
Cllr Chuck Berry
Cllr Trevor Carbin
Cllr Terry Chivers
Cllr Dennis Drewett
Cllr Peter Evans
Cllr Sue Evans
Cllr David Jenkins
Cllr Julian Johnson
Cllr Ian McLennan
Cllr Helen Osborn
Cllr Ricky Rogers
Cllr Nick Watts

Stakeholders:

Steve Wheeler — Healthwatch Wiltshire
Diane Gooch — Wiltshire & Swindon Users Network (WSUN)
Irene Kohler — Swan Advocacy
Annette Ball — South West Ambulance Service

PART I

Items to be considered whilst the meeting is open to the public

1 **Apologies**

2 **Minutes of the Previous Meeting** *(Pages 1 - 12)*

To approve and sign the minutes of the meeting held on 15 July 2014.

3 **Declarations of Interest**

To receive any declarations of disclosable interests or dispensations granted by the Standards Committee.

4 **Chairman's Announcements**

To note any announcements from the Chairman.

5 **Public Participation**

The Council welcomes contributions from members of the public.

Statements

If you would like to make a statement at this meeting on any item on this agenda, please register to do so at least 10 minutes prior to the meeting. Up to 3 speakers are permitted to speak for up to 3 minutes each on any agenda item. Please contact the officer named above for any further clarification.

Questions

To receive any questions from members of the public or members of the Council received in accordance with the constitution. Those wishing to ask questions are required to give notice of any such questions in writing to the officer named above (acting on behalf of the Corporate Director) no later than **5pm** on **Tuesday 16 September 2014**. Please contact the officer named on the first page of this agenda for further advice. Questions may be asked without notice if the Chairman decides that the matter is urgent.

Details of any questions received will be circulated to Committee members prior to the meeting and made available at the meeting and on the Council's website.

6 **Non-Emergency Passenger Transport Service** *(Pages 13 - 32)*

The contract for non-emergency passenger transport service (NEPTS) was awarded to Arriva Transport Solutions (ATS), the contract was effective from 1 December 2013 and runs for five years. This service is for patients who have a

non-emergency medical need and require help with transport to reach their hospital appointment.

At the meeting on 11 March, the Committee expressed concern having received reports of poor experience for some patients and flows through the acute hospitals being affected due the capacity constraints of ATS. A summary of the type of complaints was given and it was found that most fell into the following categories:

a) Waiting times for collection (from hospital);
b) Ability to make bookings via the website;
c) Errors with bookings

These complaints must be investigated and responded to within 25 days.

Some explanation was given to the types of complaints made under the aforementioned headings, stating that previously the PTS contract had inherited three different methods of booking and tracking as a result of the three different Acute Hospitals that the PTS contract serves. This had been somewhat resolved since Arriva had implemented a unified booking system for all Acute Hospitals in the county.

Member's attention was drawn to an action plan developed by Arriva in accordance with Acute Hospitals in the County which allows for better management and monitoring of the service.

It was resolved that the Committee would receive the attached performance update report at this meeting.

Andy Jennings, Commissioning Manager, CCG and Ed Potter, Arriva Head of PTS South West, will be in attendance to present the report and respond to any questions.

7 **Care Quality Commission Inspection Report : Mears Help to Live at Home Wiltshire** *(Pages 33 - 48)*

To discuss the recent Care Quality Commission Inspection Report in respect of the Mears Help to Live at Home service on the request of the Chair and Vice Chair on account of concerns that have arisen as a consequence of the report.

Mears were awarded the Help to Live at Home contract for the East and South regions of Wiltshire on 21 August 2013 and mobilised in a four week time period; the contract commenced on 30 September 2013.

The Committee receive a Position Statement from Mears along with the Action Plan as presented to the CQC in response to the CQC Inspection Report.

It is understood that Mr Adrian Higher, as a member of the public and witness, wishes to speak to this item.

Bernadette Walsh, Chief Operating Officer and Alan Long, Executive Director of

Mears will be in attendance to respond to any questions.

8 **Care Quality Commission Inspection Report : Westbury Court Care Home**
(Pages 49 - 78)

Following concern raised by Cllrs Gordon King and David Jenkins upon reading a media report in respect of the Care Quality Commission Inspection Report on the Westbury Court Care Home's failure in an unannounced inspection; it was requested by the Vice Chairman that this item be included in the agenda.

Particular reference was made in the Report to inadequacies identified across the following: providing care, treatment & support that meets peoples' needs; caring for people safely and protecting them from harm; quality & suitability of management; and insufficient staffing.

The full CQC Inspection Report can be accessed via this link.

The Committee are asked to consider whether any further action is required and what this may entail if necessary, including its addition to the forward work programme.

9 **AWP/Dementia Task Group Final Report**

A report by Cllr John Noeken, Chairman of the Task Group, will be circulated.

10 **AWP Care Quality Commission Inspection**

AWP has recently undergone a Care Quality Commission Inspection, an update on the current position of AWP and details of the inspection will follow for discussion and review by the Committee.

11 **Charging for GP Services**

At the last meeting, the Committee received an announcement from the Chairman regarding a question posed on charging for GP services. It was noted that motions on the subject had been put forward at relevant conferences with more detailed and varied information than the Committee received. It was agreed that the item be brought back to this meeting for a fuller explanation.

Cllr Dr Helena McKeown was invited to provide additional information in support of the item. She clarified that the motion that was tabled at the last meeting was from a meeting of the Conference of Local Medical Committees that does not make BMA policy. Wiltshire LMC submitted one part of the motion and as Vice Chairman of the LMC, was asked to propose the motion, which is not her own proposal but a part of a democratic process of debate.

Cllr Dr Helena McKeown further explained that the British Medical Association makes its policy at its Annual Representative Meeting on 26 June, where she

submitted a motion through the agreement of the BMA's South West Regional Council, set out below:

i) rejects any proposal of a means tested monthly levy to pay for the NHS;
ii) rejects the proposals from the Commission on Health and Social Care that the way to pay for social care is to charge for either GP or hospital appointments;
iii) demands that the funding of long-term social care is resolved without jeopardising the principles of the NHS;
iv) reasserts our belief as doctors that universal healthcare must be free at the point of delivery and available to all regardless of an individual's ability to pay.

All parts of this motion were passed either unanimously or with overwhelming support, as is the policy of the British Medical Association.

The Committee is asked to be aware of the context of the issue in the light of the original announcement and further information provided.

12 **Adults Safeguarding Annual Report** *(Pages 79 - 164)*

This item features on the forward work programme for the Committee to receive on an annual basis.

The Committee is asked to comment on the draft version of the annual Wiltshire Safeguarding Adults Board report.

Margaret Sheather, Independent Chair, Wiltshire Safeguarding Adults Board, will be in attendance to present the report and respond to any questions.

13 **Draft Joint Mental Health & Wellbeing Strategy** *(Pages 165 - 190)*

To review the Draft Joint Mental Health and Wellbeing Strategy.

Cllr Sheila Parker, Portfolio Holder for Adult Care - including Learning Disability and Mental Health, will be in attendance to present the Strategy and respond to any questions. The Strategy will have received by Cabinet on 16 September.

14 **Public Health Annual Report** *(Pages 191 - 210)*

To review the Public Health Annual Report 2013-14.

Maggie Rae, Corporate Director, will be in attendance to present the report and respond to any questions. The Report will have been received by Cabinet on 16 September.

15 **Report on Health Scrutiny Guidance** *(Pages 211 - 218)*

At the last meeting, it was resolved that the Committee would receive a report

on the long awaited Local Authority Health Scrutiny Guidance. A report by Paul Kelly, Scrutiny Manager is attached.

The Guidance has previously been circulated and can be found via the following link.

The Committee is asked to agree the recommendations in the report.

16 **Task Group Update** *(Pages 219 - 220)*

Written updates on Health Select Committee Task Group activity are attached.

17 **Forward Work Programme** *(Pages 221 - 222)*

To note and receive updates on the progress of items on the Forward Work Programme.

The relevant extract from the Overview and Scrutiny Forward Work Programme is attached for reference.

Meetings with the Executive

A round of meetings are currently being held (based on those held following the Council election in 2013) between the Chairmen and Vice-Chairmen of the Select Committees and the relevant Cabinet members, Portfolio-holders and Associate Directors to review and develop Overview and Scrutiny's Work Programme aligned to the Council's Business Plan. As before, a focus on outcomes and invitations to develop policy with use of single-topic, time-limited Task Groups should feature significantly adding value to Council decision-making.

The following meetings have been scheduled with the Chair and Vice Chair:

7 October - Adult Care to include Mental Health with Cllrs Keith Humphries and Sheila Parker; and James Cawley.

14 October - Public Health with Cllr Keith Humphries and Deborah Haynes.

The outcomes of these meetings will be reported to the subsequent meeting.

18 **Urgent Items**

To consider any other items of business that the Chairman agrees to consider as a matter of urgency.

19 **Date of Next Meeting**

To note that the next scheduled meeting of this Select Committee is due to be held on Tuesday 18 November 2014, starting at 10.30am at County Hall, Trowbridge.

PART II

Items during whose consideration it is recommended that the public should be excluded because of the likelihood that exempt information would be disclosed

None

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Wiltshire Council
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HEALTH SELECT COMMITTEE

DRAFT MINUTES OF THE HEALTH SELECT COMMITTEE MEETING HELD ON 15 JULY 2014 AT KENNET ROOM - COUNTY HALL, TROWBRIDGE BA14 8JN.

Present:

Cllr Chris Caswill, Cllr Mary Champion, Cllr Christine Crisp (Chair), Cllr Mary Douglas, Diane Gooch, Cllr Bob Jones MBE, Cllr Gordon King, Cllr John Knight, Irene Kohler, Cllr Helena McKeown, Cllr Jeff Osborn, Cllr Nina Phillips, Cllr Pip Ridout, Cllr John Walsh and Brian Warwick

Also Present:

James Cawley (WC), Jo Cullen (CCG), Christine Graves (Healthwatch), Cllr Alan Hill, Cllr Keith Humphries, David Noyes (CCG), Cllr Sheila Parker and Dr Stephen Rowlands (CCG)

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51 **Election of Chairman**

The Democratic Services Officer sought nominations for Chairman for the 2014/15 municipal year.

Resolved:

Councillor Crisp was elected Chairman of the Health Select Committee for the 2014/15 municipal year.

Councillor Crisp in the Chair

52 **Election of Vice-Chairman**

The Chairman sought nominations for the position of Vice-Chairman of the Health Select Committee for the 2014/15 municipal year.

Resolved:

Councillor Noeken was elected Vice-Chairman of the Health Select Committee for the 2014/15 municipal year.

53 **Apologies**

Apologies were received from Steve Wheeler – Healthwatch Wiltshire.

The Chairman noted that it was Mr Warwick's last meeting as a committee member.

Cllr Knight, Cllr Walsh and Mrs Irene Kohler were welcomed as committee members.

A query over the suitability of the room was noted.

54 **Minutes of the Previous Meeting**

The minutes of the previous meeting held on 6 May 2014 were presented.

An amendment to minute number 46 – Committee Membership to change the wording of the second sentence to read

'The Southwest Seniors Network, of which Mr Warwick was the Chairman, would hold their AGM in September, at which they would suggest a new representative.'

was agreed.

It was noted that if, during a debate, a member wished a specific item to be recorded or a resolution changed that, for the sake of clarity, the Committee would vote on the issue at the time.

Resolved:

To sign and agree the minutes of the previous meeting as a true and accurate record, subject to the amendment detailed above.

55 **Declarations of Interest**

Cllr Dr Helena McKeown declared a non-pecuniary interest being a GP, the Vice-Chairman of the Wiltshire Medical Committee and a member of the British Medical Association Council.

Cllr Noeken declared a non-pecuniary interest being a governor of the Salisbury District Hospital Foundation Trust.

Cllr Douglas declared a non-pecuniary interest as her husband worked as a nurse in a stroke ward at Salisbury hospital.

Cllr Walsh declared a non-pecuniary interest being the Chairman of South West Mencap.

56 **Chairman's Announcements**

Health Scrutiny Guidance
The Committee heard that the long awaited Local Authority Health Scrutiny Guidance has been published. A report on this will come to the next meeting, and the document circulated to members.

Letter from RUH
A letter from James Scott at the RUH assured the Committee that the hospital had ensured a smooth handover of the maternity services from the GWH. They have also appointed a consultant paediatrician and divisional manager to support the new Women's and Children's Division.

Delayed transfer to care
The DtoC Task Group is now regularly reviewing the DtoC figures and the actions being taken to address them. It was agreed that to avoid duplication the Task Group continue to monitor the monthly reports and for the Committee to receive 6 monthly updates on the figures.

Equity for mental health
From 1 April 2014 patients with mental health conditions have had the same rights as physical health patients to choose where they have their first outpatient appointment. NHS England are seeking feedback on the interim guidance they have produced for commissioners and providers on the new legal right. Guidance produced by NHS England to support patients is to follow.

Police update
Angus Macpherson updated the HWB on several items of interest to the Committee.

Safe Places Scheme:
Organisations such as shops and community centres that sign up to the Safe Places Scheme, provide safe places for people who might be overtaken by sudden memory loss, confusion or panic. A large orange sticker identifies the safe places and their staff are trained to assist vulnerable people. Angus reported that sign up to the scheme was going well.

New worker:
The Police have appointed a Mental Health Liaison Officer to work with other agencies to support the Concordat that is looking to improve the system of care and support so that people experiencing mental health crises are kept safe and helped to find the support they need.

Young people:
In the past there has been criticism in Wiltshire that young people under 18 years of age, who are detained under s136 of the Mental Health Act, have been detained in police cells as there have been no health based place of safety.

This has now addressed and accommodation is now provided at Fountains Way Hospital in Salisbury. In 2013 – 14, all 5 young people detained stayed in a health-based place of safety.

Charging for GP services

Members noted that the Wiltshire Local Medical Committee proposed a motion to their national conference in May. There were 5 parts to the motion and 2 were passed.

The Committee approached the Wiltshire CCG for a comment on their position and the statement provided together with details of the proposed motions can be found on the document circulated at the meeting and attached to these minutes.

The Chairman noted that motions had been put forward at other conferences where more detailed information had been available and if the Committee wished to debate the item it would be at another time when the full facts were available.

Cllr Dr McKeown noted that South West Region Council had put forward different information, meaning members had not been fully informed and requested her objection be minuted.

The Committee agreed that the item be brought to the next meeting.

57 **Public Participation**

Cllr Caswill stated that as charging for GP services was now coming to a future meeting of the Committee he had no further questions.

There were no further questions or statements received.

58 **Performance report on NHS 111**

The Committee welcomed Jo Cullen, Group Director for the West Wilts, Yatten Keynell and Devizes (WWYKD) Group who presented the report, noting there were three areas for concern:

- Ambulance Disposition Rate
- Activity sent to Accident and Emergency
- Warm Transfer Rate

Although slight improvements had been seen, it was not as much as had been hoped. The unprecedented unseasonal activity was noted, being as busy as New Years Eve in June. This was a national problem and the CCG were trying to understand the reasons behind it.

Fewer calls were resulting in a 999 call and they were working with Care UK to reduce the number of calls. From April they have been able to identify where calls had been advised to visit a minor injuries or day care unit, which provided more data for analysis.

Staffing at the Bristol call centre was still an issue and a weekly recovery plan was in place to ensure sufficient staff were in place. Some Committee members remained concerned about the performance of Care UK.

In response to questions Ms Cullen confirmed that a disproportionate amount of time was spent with the provider to address issues. Activity was increasing on the preventative medical advice line. Financial penalties were being imposed which would take effect in August. It was not yet known what had caused the increased activity. Concern was raised about the transaction costs to the CCG of supporting and monitoring Care UK's performance.

The Committee noted that their visit to Care UK in June had shown a fluid well run organisation. The whole picture was not seen in the report, and the context of the lack of money available for an out of hours GP service, the aging population in Wiltshire and fewer inpatient beds was noted. Concern was raised about the oncoming winter. It was agreed that a report detailing the broader picture be brought to the November meeting and Care UK be invited to the meeting.

Resolved:

The Committee noted the report.

59 **Continence Services Task Group Report**

59a **Executive response to the task group report**

Cllr Humphries thanked the task group for bringing issues with the continence services to his attention and confirmed a meeting was being set up with the partners involved in the service. He hoped not just for improvement but to ensure that improvements were sustained in the future.

59b **Report back from Task Group meeting with CCG**

Cllr Osborn thanked the CCG for a productive meeting and noted that the report brought to the meeting by the CCG mirrored the concerns raised by the task group. The CCG would take their report to their Clinical Executive Board being held on 22 July, and would report back after the meeting.

The task group would look at the issue again to ensure that improvements were delivered.

60 **Final Draft Dementia Strategy**

Cllr Parker, Portfolio Holder for Adult Care, including Learning Disability and Mental Health presented the final draft dementia strategy to the Committee. She explained that it set the strategic direction for the next seven years with an aim to treat people as individuals with access to the right care and support at the right time.

A public consultation had been held from 20 February 2014 to 19 May 2014. Over 100 responses had been received which were analysed and used to review and amend the strategy. The action plan which provided the detail around the strategy had been passed to the Task Group for their feedback. The strategy was due to go before the CCG on 22 July before being signed off by the Health and Wellbeing Board at their meeting on 31 July 2014. The action plan needed to be signed off by both Cabinet and the CCG's Clinical Governing Body.

The following KPI proposals were made for consideration:

- Urgent assessment by social care
- Responsiveness regarding respite care
- What is 'specialist consultancy' and suggest the time taken for this
- Dementia aware practitioners in and out of hours
- Time taken for a Continuing Health Care Assessment to be done
- Urgency assessment by complex intervention and Therapy Team
- Out of hours social care Emergency Duty Service
- Weeks of wait to assessment in memory clinic

Mr Cawley noted these and asked for the task group to consider them.

The Committee noted that there had been little change to the strategy since it had been last presented. The Task Group's scope and aim had been extended with an additional piece of work on acute dementia care, and the group hoped to have initial findings within two to three months. A vacancy had arisen in the task group and Cllr Walsh agreed to replace Cllr Phillips, who was thanked for her contribution. The Portfolio Holder for Adult Care, including Learning Disability and Mental Health was invited to attend the task group meetings.

The Council spent £14.8 million on dementia, and the CCG approximately half that, and the task group were hoping to understand how these figures were used. The Committee heard that both the Vice-Chairman of the Committee and the Chairman of the Avon and Wiltshire Mental Health Partnership had stated the need for additional funding at the Health and Wellbeing Board, however no additional funding had been given.

A request to raise the profile of Parkinson's within the strategy was noted. Concerns were raised over numbers and timescales for milestones and how

outcomes would be achieved and measured would be covered within the action plan, which was a working paper at present.

Resolved:

The Committee noted the final draft Dementia Strategy.

61 **Healthwatch Annual Report**

Christine Graves, Chair of Healthwatch Wiltshire presented their Annual Report which was a legal requirement and provided an opportunity to demonstrate the progress made in 2013/14 and to look forward to 2014/15.

Healthwatch Wiltshire had been established by the Health and Social Care Act 2012. It was a social enterprise commissioned by the council and supported by Healthwatch England, who picked out the national message from the local messages.

The purpose of Healthwatch was to be a consumer champion for health and social care champion for children, young people and adults, and for patients, service users and unpaid carers. They were the critical friend and an organisation that the public can trust. They ensured the roadmap to the future is properly influenced by the people.

A workplan for 2014/15 was available on their website, in which they looked to build on a solid base with credibility, sustainability, independence and no duplication, where they could demonstrate their impact. They hoped to contribute to the work of the Committee, providing advice and guidance from an independent perspective and lay assessment of quality through Enter and View.

In response to questions the Chairman Ms Graves confirmed that Healthwatch did not champion a point of view, but checked the proper processes had been followed and any decision made sense. They did not help people campaign.

The Committee recognised the achievements made with the funding available and noted the need for closer partnership working. Ms Graves was thanked for her presentation.

Resolved:

The Committee noted the content of the Annual Report 2013/14.

62 **Clinical Commissioning Group's 5 year Strategic Plan**

Dr Steve Rowlands, Chair of the Wiltshire CCG, and Mr David Noyes, Director of Planning, Performance and Corporate Services presented the CCG's 5 year strategic plan which was set within the context of the Wiltshire Health and

Wellbeing Strategy and set out their vision, being 'health and social care services in Wiltshire should support and sustain independent living'.

Challenges facing the CCG were people living longer, a rise in long term conditions like diabetes and dementia and budgets for NHS services not increasing in real terms. Without changes to local healthcare services the CCG would need to find an extra £60 million by 2021.

Opportunities identified were the opportunity to take on commissioning of GP services and some specialist commissioning, the Better Care Fund helping them to integrate health and social care and being part of the council's campus developments.

The CCG had identified three priorities:

1. Encourage and support Wiltshire residents to take on more responsibility for their own health and wellbeing.
2. Provide fair access to an high quality and affordable system of care for the greatest number of people
3. Provide less care in hospitals and more care at home or in the community

In order to spend more on health education and prevention, and improving community care the CCG would need to spend less on providing bed-based care in hospital. Care would be centred around the patient and there would be twenty community team clusters.

The public had been consulted on the strategic plan through public meetings, outreach into youth groups, mother and baby groups and University of the 3rd Age. Engagement would continue through a series of integrated health and social care workshops with council colleagues to be delivered in the autumn to area boards, and through media coverage.

In response to questions it was confirmed that the community teams would be travelling to patients and supporting at home where possible. The CCG recognised that change would be difficult and would take time to deliver, and it was important to set off in the right direction. The importance of timing and communication was noted and the CCG agreed that there would be double running costs for a while until it was known that community services were running appropriately. They were working closely with all colleagues in order to help people to help themselves and making to do the right thing simple.

The Committee noted the need to monitor the delivery of the plan closely. It highlighted the challenge in getting the general public to take responsibility. Attention was drawn to successful projects in other areas such as the deep end project in Glasgow and playgrounds for adults. It noted the opportunities for co-commissioning with GP's, which may also help with expanding primary care. Concern was raised over whether enough work was being done on the issue of

the ageing population, the lack of joined up thinking on strategies for ageing societies, and whether engagement had included all groups as detailed in statute.

The CCG explained that some engagement had taken place and acknowledged that some could have been done better and more effectively. The 5 year plan and vision was the starting point in addressing the issue of the ageing population. It defined the outcomes the CCG wanted to achieve for the people of Wiltshire. Communications regarding the plan would be in every form of media. They welcomed the assistance of Brian Warwick on this topic.

The Committee thanked Dr Rowlands and Mr Noyes for their presentation.

Resolved:

The Committee noted the CCG's 5 year Strategic Plan.

63 **Task Group Update**

Transfers to Care Task Group
A meeting of the task group was held on Thursday 10 July at which John Rogers, James Roach and Sue Geary were present. A spike had been seen in the figures for April to June, and an understanding was gained of where the real issues were, being different in different hospitals. The Committee would be notified of any figures which required detailed explanation.

It was noted that this was fundamental to the CCG's 5 year strategic plan.

Avon and Wiltshire Mental Health Partnership / Dementia Services
Reference was made to the comments made in the final Dementia Strategy update, minute no. 60 referred.

Help to Live at Home Task Group
The inaugural meeting of the Help to Live at Home Task Group is being arranged.

64 **Forward Work Programme**

The Committee noted the forward work plan.

65 **Urgent Items**

There were no urgent items.

66 **Dates of Future Meetings**

The date of the next meeting was confirmed as Tuesday 23 September 2014, at 10.30am and would be help in the Kennet Room at County Hall, Trowbridge, Wiltshire BA14 8JN.

The Committee noted the future meeting dates for 2015/16.

Mr Warwick thanked the Chairman and both members past and present for their help and guidance, and thanked Cllr Humphries and his predecessor, Cllr Thomson, for their work with older people.

The Chairman on behalf of the Committee thanked Mr Warwick for his contribution to both the work of Health Select Committee and the work of the council.

(Duration of meeting: 10.30 am - 1.30 pm)

The Officer who has produced these minutes is Kirsty Butcher, of Democratic Services, direct line (01225) 713948, e-mail kirsty.butcher@wiltshire.gov.uk

Press enquiries to Communications, direct line (01225) 713114/713115

Wiltshire Council

Health Select Committee

15 July 2014

Chairman's Announcements (additional information)

Local Medical Committee – Annual Conference

At the Local Medical Committee's (LMC) Annual Conference in May 2014, the Wiltshire LMC proposed the following motion:

That conference:

(i) believes that general practice is unsustainable in its current format; (**Passed**)

(ii) believes that it is no longer viable for general practice to provide all patients with all NHS services free at the point of delivery;

(iii) urges the UK governments to define the services that can and cannot be accessed in the NHS; (**Passed**)

(iv) calls on GPC to consider alternative funding mechanisms for general practice;

(v) calls on GPC to explore national charging for general practice services with the UK governments.

The motion was debated and parts (i) and (iii) were passed.

Wiltshire Clinical Commissioning Group

The Wiltshire CCG was approached for a comment on their position for the Committee and they provided the following statement.

Wiltshire Clinical Commissioning Group was not aware that the Local Medical Committee were proposing a motion to the LMC national conference that patients should be charged.

As a CCG, we do not support this motion as NHS patients should have access to a free service at first point of delivery when they attend an appointment at their local surgery.

The purpose of the motion was to spark a debate around patients being charged and to address the upcoming crisis with regards to the recruitment of doctors in rural counties.

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NHS
Wiltshire
Clinical Commissioning Group

Wiltshire Clinical Commissioning Group Report for Wiltshire Council Health Select Committee:

Arriva Non-Emergency Patient Transport Service

September 2014

1 INTRODUCTION

This report builds on the report provided to the Committee in February 2014. As a result, the context and historical background is not repeated. The service has now been running for 9 months, since 1 Dec 2013.

This report focuses on:

- Governance
- Activity
- KPI performance
- Quality
- Complaints
- Service user survey
- Service improvements

2. GOVERNANCE

Routine contract governance takes the form of a series of meetings and supporting data reports.

- Monthly contract performance meeting (Arriva and CCGs)
- Bi-monthly clinical quality review meetings (Arriva and CCGs)
- Monthly transport working groups (Arriva and acute trusts)
- Monthly activity and performance reporting (at CCG contract level; and local trust-specific data analysis)

3. ACTIVITY

Updated activity charts are shown at Appendix 1. These are Non-Emergency Patient Transport Service (NEPTS / PTS) journeys, conducted by Arriva, for patients registered to a GP practice within Wiltshire CCG. The journeys are a combination of actual journeys completed, plus aborted journeys[1], but excluding cancelled journeys[2].

As previously reported, the CCG now for the first time has a single comprehensive data set as a result of the single PTS contract. This shows that the actual activity conducted, varies from the activity detailed in the tender process, and against which the provider put resource in place. This variance has three main elements: average journey distance; total activity; activity per mobility type. The peak daily requirement profile is also different to the tender data. This in turn places considerable pressure on the service and specifically impacts on the timeliness of service delivery – itself one of the key quality measures and one of the most important elements of patient safety and experience.

[1] Aborted journeys are billable, since they are journeys where NEPTS resource has been committed to the task, but the task was not completed. This can be for one of a multitude of reasons (e.g. patient not ready / patient too ill to travel / patient no longer requires transport / appointment cancelled but transport was not / patient too ill to travel / patient used own transport / patient had been admitted but transport not cancelled / etc.)

[2] Cancelled journeys are those for which a booking was made but, are cancelled prior to the start of the journey, by the person/organisation that made the booking. Cancellations are not billable.

The variances being managed are as follows (see charts at Appendix 1):

- Average mileage per journey: +15% above tender expectation
- Total activity: 6% above tender expectation
- Variances in number of journeys per patient mobility category are shown at Appendix 1. These impact on the requirement per vehicle type required

Variances in the volume, mileage and mobility mix of other CCGs' activity, also have a bearing, since Arriva provides a PTS service to 4 local CCGs, and excessive pressure in one area will have an impact in other areas.

In order to ensure - despite these variances, and the resulting resource gap compared to actual demand - that all eligible Wiltshire patients are able to be transported by the PTS service, the CCG has supported the use of additional non-recurrent funding in-year. This is specifically for the provision of additional third party PTS capacity to fill this resource gap. At the end of the first contract year, the contract enables a revision of activity to enable these variances to be taken into account on a recurrent basis. This will then mean that this activity will be delivered by the PTS provider core fleet (less contractually-mandated 10% subcontracted).

4. KPI PERFORMANCE

Detailed Key Performance Indicator (KPI) charts are shown at Appendix 2 showing performance for:

- all Wiltshire CCG patients transported by Arriva
- all Wiltshire CCG dialysis patients transported by Arriva
- all Wiltshire patients attending the three acute trusts to which majority of our patients attend, transported by Arriva.

The main Key Performance Indicator (KPI) measures shown, look at three aspects of patient experience:

- time spent on vehicle
- on-time inbound journeys
- on-time collection for outbound journeys

- Time on vehicle. Overall, performance is being achieved in line with KPIs for time on vehicle.

- Inbound on time. Inbound on-time is an area where performance has improved but requires continuing improvement to get to, and be sustained at, KPI level.

- Outbound on time (on-day bookings). This is generally being achieved or exceeded. The response timeframe for these journeys is four hours from the time the patient is "made ready". Further analysis is included which shows for June and July that 55% of on-day booked journeys are achieved within 2 hrs, 70% within 3 hours and 80% within 4 hours.

- Outbound on time (pre-booked bookings). The area requiring greatest improvement is on-time collection for pre-booked outbound journeys. The response timeframe for these is one hour from the time the patient is "made ready". Further analysis is included which shows for June and July that although only 76% were achieved within the one hour compared to the KPI target of 85%, a further 11% were achieved within the next 30 minutes, a further 6% within the 30 minutes after that.

Performance for dialysis patients is significantly higher than for the full patient cohort, reflecting the routine nature of these journeys.

Despite the complexity of managing a different profile and volume of activity, currently being addressed through reliance upon additional capacity from third party providers, overall performance has improved since contract start. Further improvement is required in order to achieve all KPI target levels in a sustained manner. One year after contract start, December 2014, is the first contractual opportunity to revise the baseline activity and mobility requirements. This will ensure Arriva thereafter has the right resource in the right places to deliver the type, mix and volume of activity, based on a full year's data gathered since contract launch. This will reduce Arriva's reliance on third party resources and consequently enable better overall performance.

5. QUALITY

A Clinical Quality Review Meeting comprising Quality leads from CCGs plus Arriva meets every 2 months. This has resulted in a focus on a wide range of quality-related issues. The CCG quality team feel assured about the quality of the service provided. Arriva provide monthly information on a range of quality measures that inform formal quality reports that are considered by this group which focuses on clinical effectiveness, patient safety and patient experience.

The Clinical Quality Review group have reported that Arriva have been receptive to constructive comments and willing to change and/or adapt their processes for quality monitoring and reporting accordingly. The Clinical Quality Review group have started an end- to-end walk through process to enable the sharing of learning across the group and with the provider.

At the August clinical quality review meeting, the following topics were covered:

- Workforce and staffing
- Training
- Reportable incidents
- Quality management: safeguarding
- Patient experience: concerns, comments, complaints and compliments
- Infection prevention & control: annual programme
- Sustainable development management plan
- Sub-contractors: monitoring; action plan update
- Operational audit plan
- Agency staff induction checklist
- Quality schedule

6. COMPLAINTS

Figure 1: Number of contacts received by Arriva including comments and commendations

Month	Number of contacts
January	159
February	77
March	78
April	60
May	85
June	75
July	83

(across all 4 CCGs served by Arriva)

A full report detailing complaints received, trends, themes and actions, was presented to the CQRM. Detailed analysis of a specific complaint and the process followed will take place at each Quality Monitoring Group from October 2014 for additional assurance.

Figure 2. Contacts June/July 2014 broken down by area

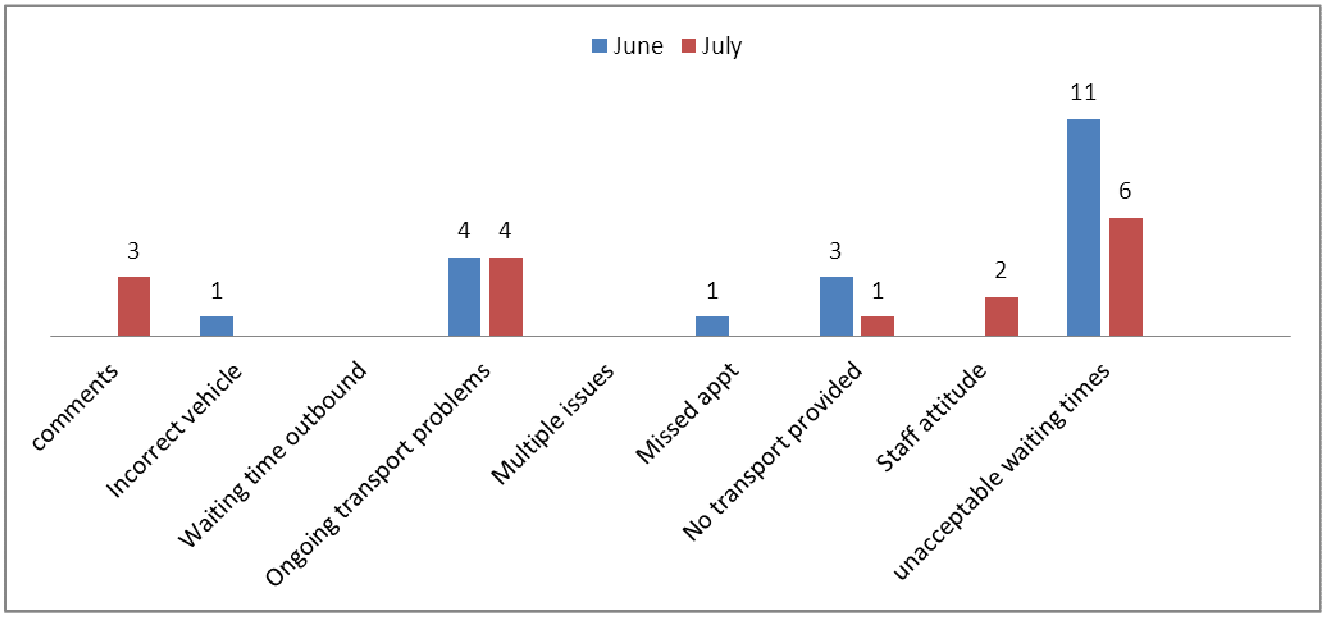
CCG Area	June	July
Wiltshire	20	16

The number of complaints from Wiltshire patients was commensurate with the numbers received by the other CCGs using Arriva, and in similar proportion to the number of total journeys completed.

Figure 3. Patient Journeys

Activity	Wiltshire
Jan	5315
Feb	4804
March	4988
April	5698
May	5850
June	4977
July	5585

Figure 4. Complaint type, Wiltshire, June and July 2014



Issues specifically identified by acute trust providers, and on which action is also being taken, can be divided into a number of areas, most of which relate to the impact of timeliness:

- Overall timeliness of collection/drop-off, as shown in the KPI scores, where improvement to a sustained level at or above KPI target is still required. Both the commissioners and Arriva have acknowledged that resources available have not always met the full requirement for non-emergency transport. Commissioners have agreed a temporary arrangement to support the mobilisation of additional resources by Arriva. Both parties have agreed to use the first 12

months of activity data to support a contractual rebasing process as specified within the contract.

- Delay in transport for some vulnerable patients. There are cases of delays in transporting certain patients identified as vulnerable, for example those patients who need transport within two hours. Delays for these patients and their carers can cause anxiety due to the complexity of discharge planning and the need for co-ordination with other support services. A faster on-day response than currently contractually commissioned, continues to be an area for resolution between commissioners and Arriva.

- Some of those who have experienced delays to some of their (either inward and/or outbound) journeys are patients with a series of appointments such as oncology/radiotherapy outpatients. As frequent users, the impact of delays is heightened compared to other users of the service. Performance for dialysis patients is much improved, indicating what can be achieved and what we aspire to see achieved for the other groups of frequent users.

- There continue to be some examples where the impact of an excessive delay can, at its worst, result in an overnight re-admission or potentially detrimental impact on patients. All of these incidents are investigated by Arriva and the trust, and the learning actions identified and agreed with Arriva, and the trust as appropriate.

- Working relationships between acute providers and Arriva, have developed and improved, and mutual understanding of issues, concerns and constraints is much improved in both directions. Much of this is a result of the establishing of joint acute trust/Arriva transport working groups at each acute trust, and other routine and now well established on-site co-ordination between respective staff.

- Provider knowledge and use of the Arriva system, which was initially patchy, has improved and continues to be an area receiving regular attention within trusts, through a variety of means.

Lessons Learnt

CCGs are keen that the provider implements learning and improves performance as a result of issues identified through patient complaints and other feedback e.g. from acute trusts. Work currently being taken forward by Arriva, directly as a result, includes:

Communication, ongoing transport issues

- Private taxis and other third party providers have been communicated with further, to ensure that regular contact is made with the control room to give information of any delays and issues experienced. This will ensure that patients do not encounter problems and if so, they are notified that something is being done. The Arriva compliance manager is also making visits to taxi basis discussing such patient experience.

- The South West control room is establishing a process to provide information proactively to wards and clinics in the event that return transport is delayed for any reason, thus reducing stress upon patients and providing a reliable flow of information.

- Call handlers to ensure that contact numbers are included within the booking details. This will ensure that any information on possible delays can be communicated and ultimately reduce the patient's anxiety.

Delayed transport issues:

- Reviewing the provision of transport for regular patients, including dialysis and oncology patients, to ensure that comments about suitability or reliability of transport are reflected and where appropriate, transport arrangements are revised. In other cases, the ATSL position has been clarified.

- Undertaking a significant roster review to more closely match ATSL capacity with actual journey demand; thus ensuring that appropriate resources are available at the times of highest demand, and in turn reducing the likelihood of delays for patients.
-
- Priority lists have been developed for those patients who seem to have endured repeated transport issues. This will ensure that their journeys are managed much better and are in line to meet their expectations.

Extra vehicles and staff to assist with demand:

- New recruits have joined Arriva. This includes voluntary care drivers as well as salaried staff. Additional vehicles have also been sourced. This will enable higher levels of resource during busier periods, ensuring improved on time resources.

Patients experiencing repeated problems:

- Where appropriate local managers direct telephone numbers have been given to patients who have raised serious complaints to ensure that any future issues can be escalated quickly and the issue can be resolved without delay.

- Home visits have been made, giving the patient the time and platform to raise how they felt the complaint was handled and the resolution provided.

SERVICE USER SURVEY

In May/June 2014 Arriva conducted a service user survey. 4,000 freepost survey cards were available to service users/their carers from across the 4 CCGs, in hospital waiting areas. The survey was also available online. 282 responses (7%) were received. 58 of these were from Wiltshire patients/their carers.

Patients were asked their views on three aspects of service quality and experience: was the journey comfortable; did the patient feel safe and cared for by Arriva staff; and was communication with/from Arriva satisfactory/did the patient feel listened to.

Results for Wiltshire were:

Question	Satisfied	Neither satisfied nor dissatisfied	Not satisfied
Vehicle comfortable	93%	3.5%	3.5%
Felt safe & cared for	96.5%	0%	3.5%
Communicated with & listened to	91.2%	3.5%	5.3%

Overall the results were positive. The patient survey also included a range of positive comments;

"Best transport ever received"
"Transported safely and with utmost care from the driver"
"Cheerful and reassuring staff"
"Staff are fantastic, always courteous, efficient, caring and double checking father and I are secure
"Professional and good humoured"

Separately, one commendation has been received:

"I have just come out of Great Western Hospital, Swindon, and took advantage of your excellent service to return home to Yatesbury, Wiltshire".

The main cause of dissatisfaction was related to timeliness. An action plan based on the raw feedback is being implemented by Arriva. A component of this is how to improve the response rate for future service user surveys.

7. SERVICE IMPROVEMENTS

Building on the list of improvement actions described in the previous report, Arriva, commissioners, and acute trusts, have continued to work on service improvements. Typically these involve measures to improve the reliability and timeliness of meeting planned journey times, since this is the area where improvement is most necessary. There are roles for all three organisations (CCG, Acute trusts, PTS provider) in achieving this: CCGs: to hold the provider to account for performance, at the same time as ensuring the service is adequately resourced. Acute trusts: where possible planning ahead to reduce the impact of an excessive volume of on-day activity; and ensuring their staff have a good understanding of the Arriva system for bookings. Arriva: to make the most efficient and effective use of their resource, and ensure close engagement and co-ordination with acute trust staff and patients; and identify further opportunities to improve patient experience and service effectiveness.

Transport Working Groups have been established and are operated at the acute trusts and are an example of the work being done to improve the interface between the acute trusts and Arriva. These are attended by acute trust and Arriva staff, and they review activity and performance data; and identify and resolve operational issues, problems and trends. Progress is further reviewed at monthly contract review meetings.

Feedback from patients and provider organisations continues to highlight some adverse issues, and these are being used by Arriva (and the acute providers) as areas for improvement.

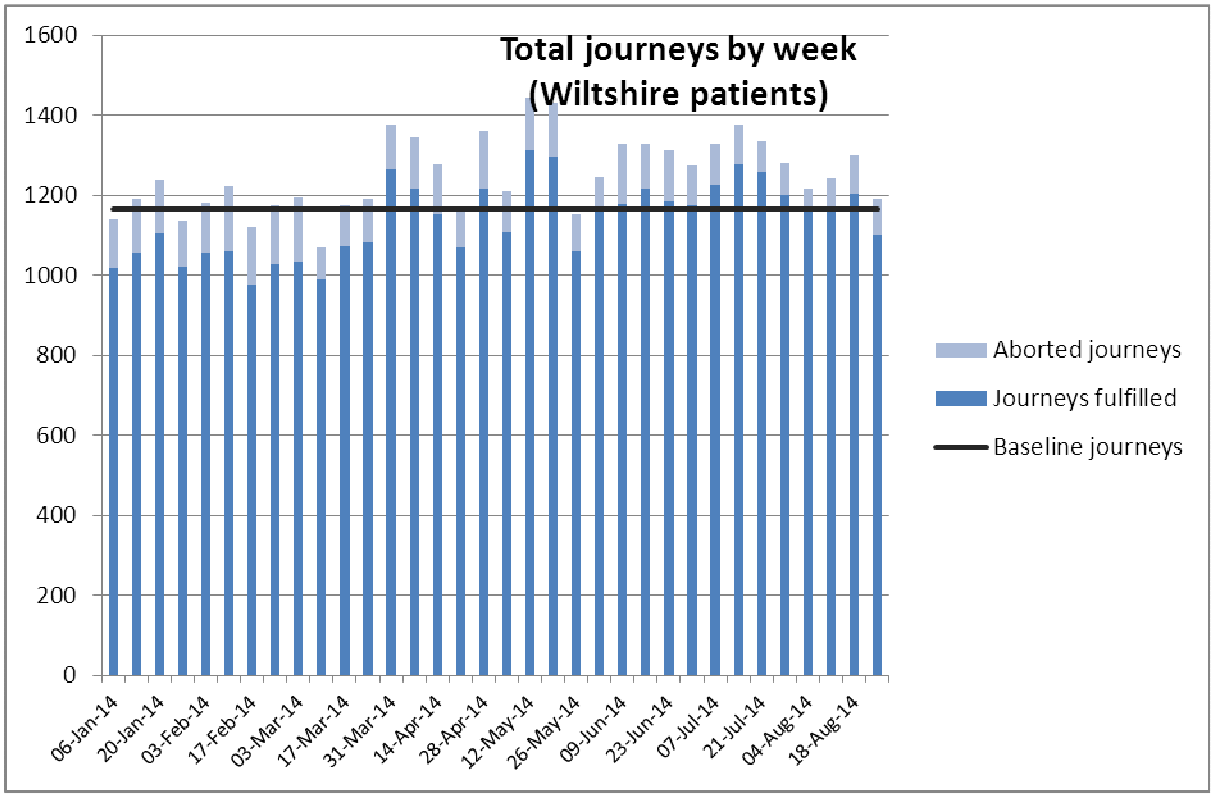
The acute trusts and Arriva have worked to improve staff relationships and the way they work together. Arriva are producing new staff information leaflets and the Trust intranet patient transport page has been re-written and will be launched shortly. The escalation procedure for reporting problems has been clarified and circulated.

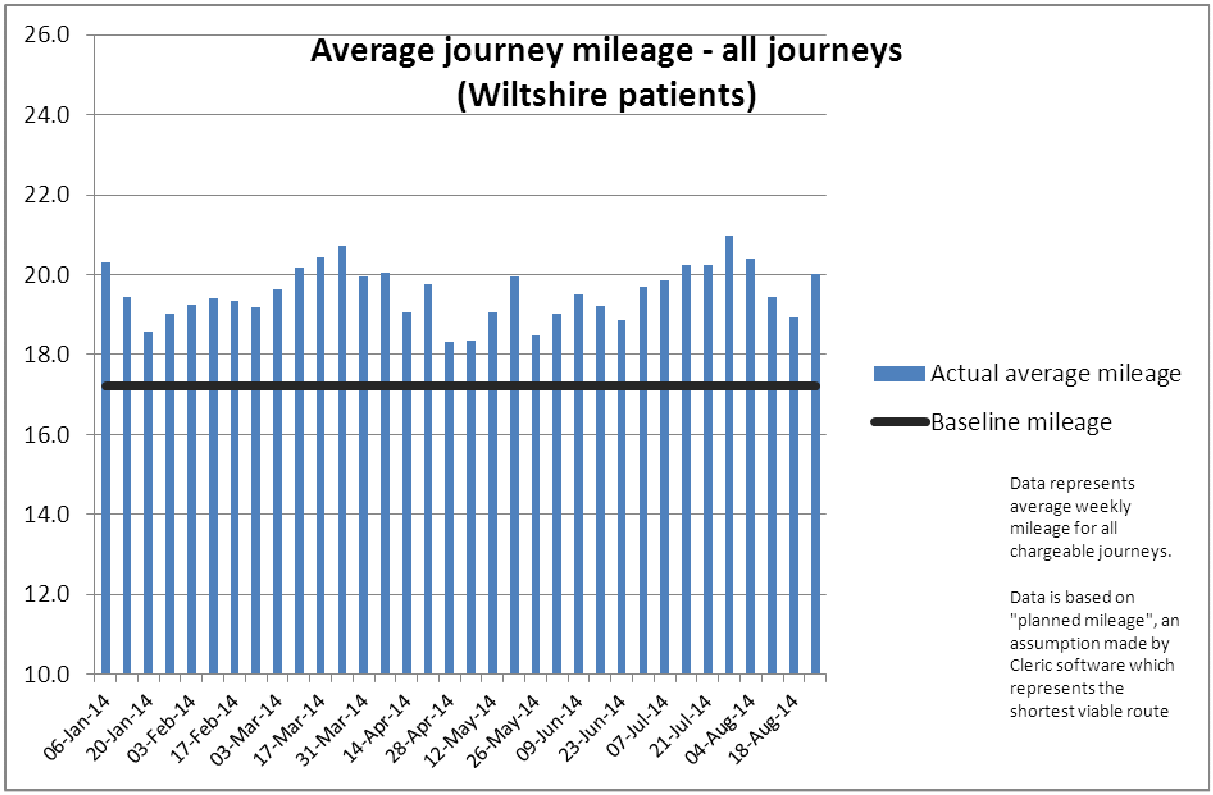
Most recently the PTS service has been refined to help provide faster on-day responsiveness for patients using the new 15-bed step-up model that is being piloted at Warminster community hospital, as part of Wiltshire's 100 Day Challenge.

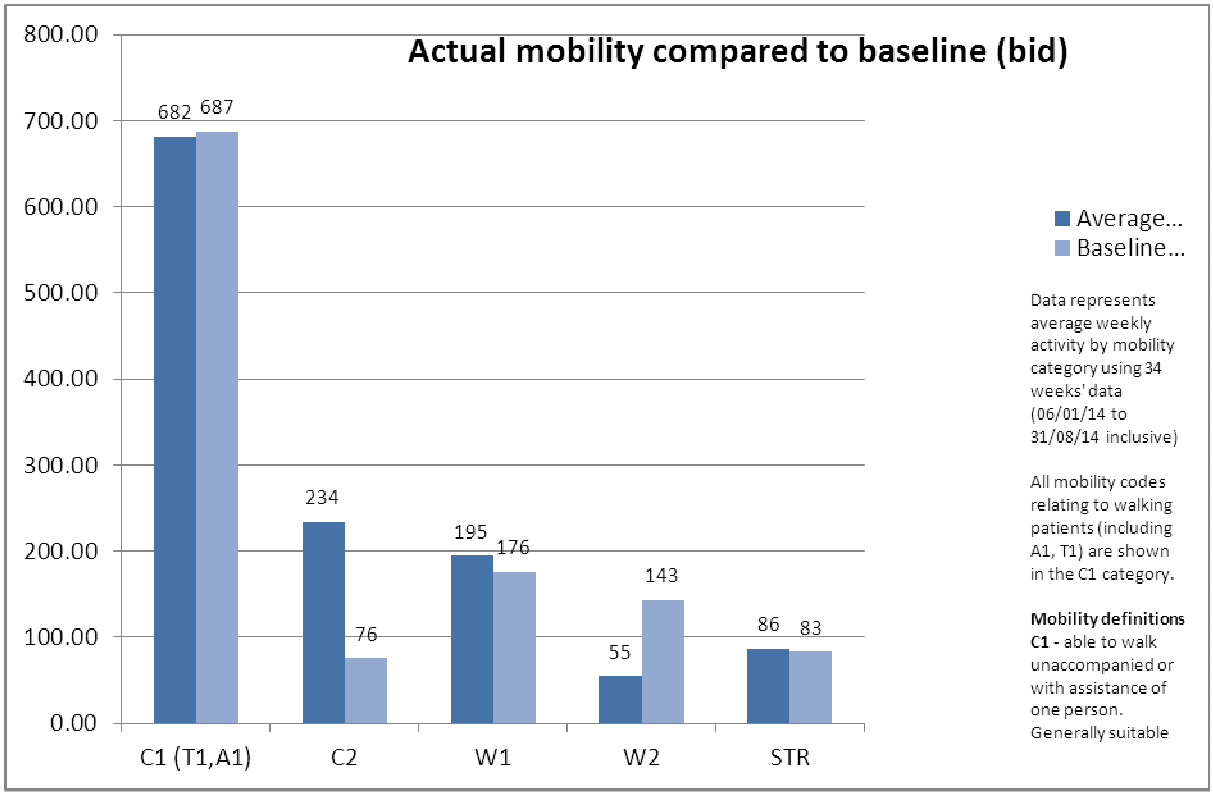
8. CONCLUSION

It is clear that the introduction of a new NEPTS service with a single provider supporting the needs of 4 CCGs, replacing a diverse, ad hoc, often poorly understood and poorly controlled set of patient transport arrangements, has not been without its issues. Many of these issues are the inevitable result of the contract being based on inaccurate and incomplete data, as a result of the preceding fragmented arrangements. Now that we have a single and comprehensive view of the data, we are much better placed to ensure the service is appropriate and is performing to required standards consistently across the CCG area.

APPENDIX 1 – ACTIVITY







Mobility definitions

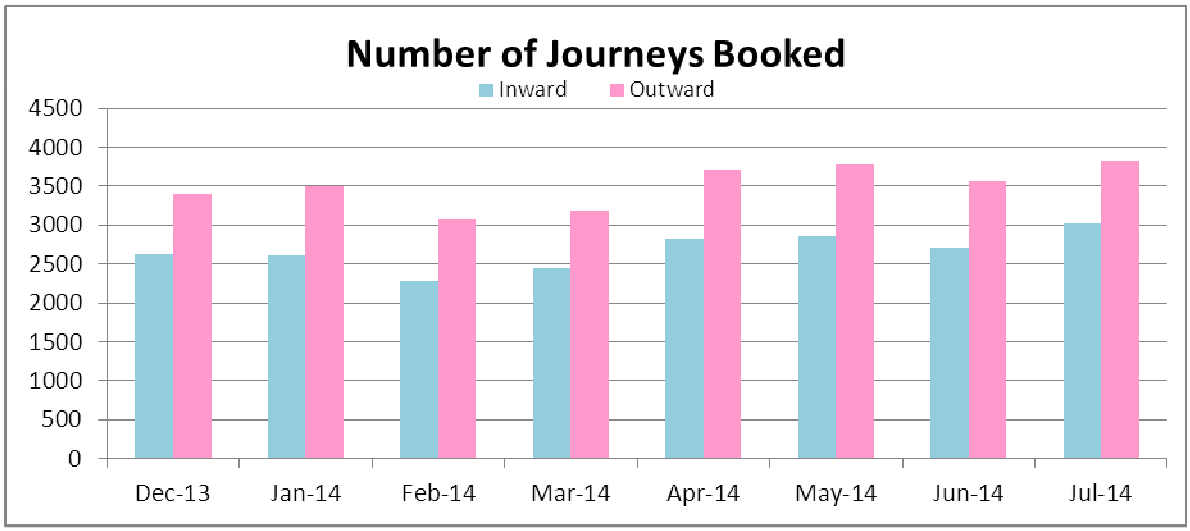
C1 - able to walk unaccompanied or with assistance of one person. Generally suitable for travel by taxi or car.

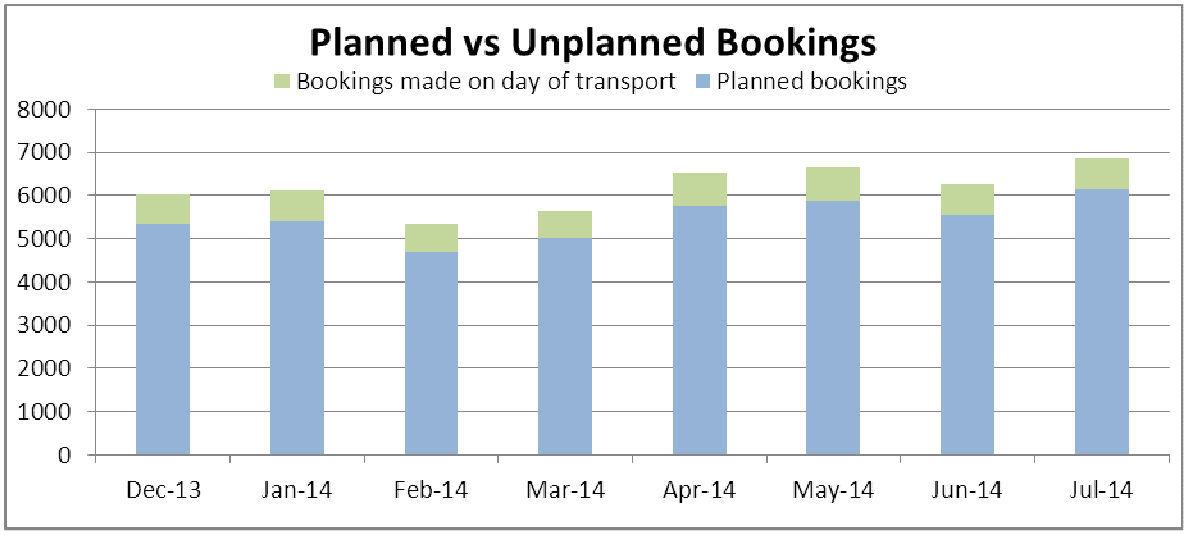
C2 - able to walk but with assistance of two people; or requires a wheelchair to be provided for transport purposes. Generally will travel by ambulance.

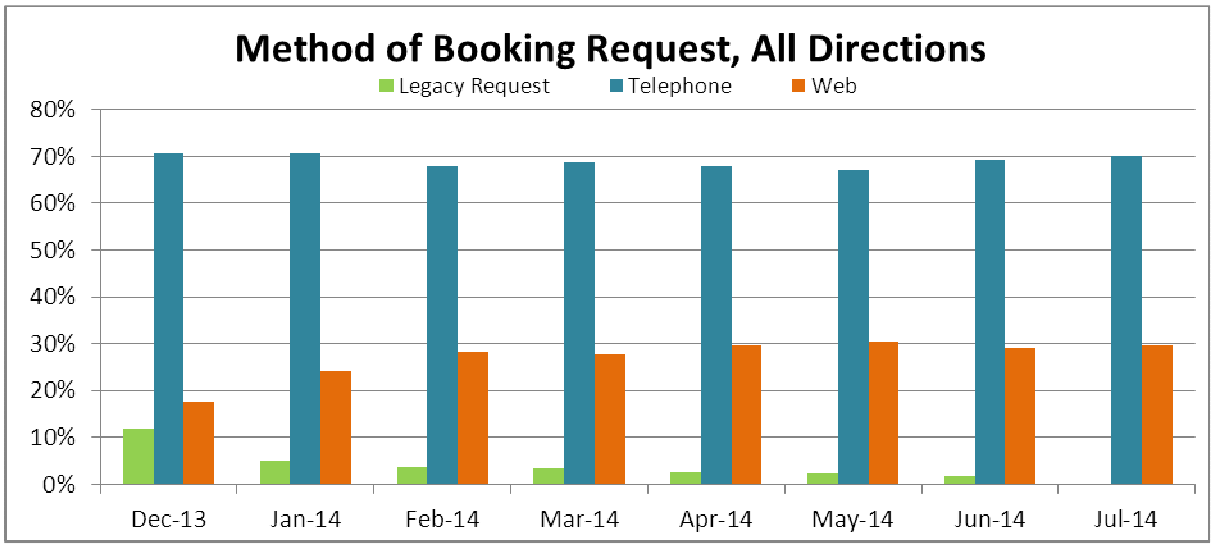
W1 - wheelchair user who is generally suitable for travel in a wheelchair-adapted car.

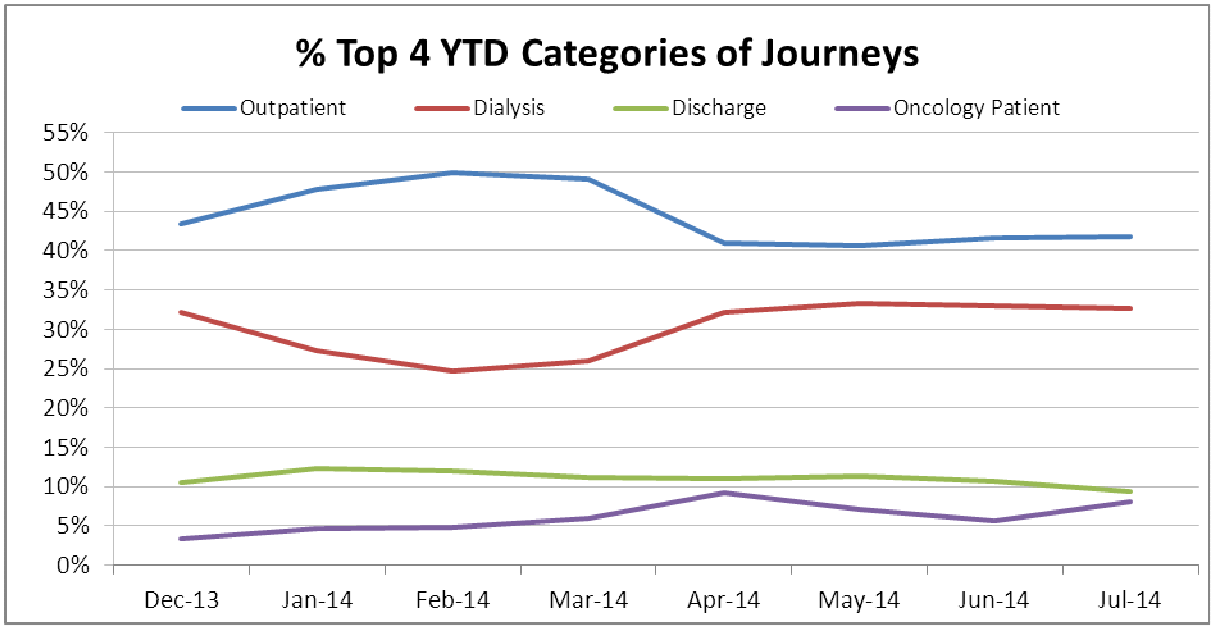
W2 - wheelchair user who is generally suitable for travel by ambulance; requires assistance of two people.

STR - only able to travel on a stretcher. Ambulance patient.




Planned vs Unplanned Bookings
Bookings made on day of transport
Planned bookings
8000
7000
6000
5000
4000
3000
2000
1000
0
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14


Method of Booking Request, All Directions
Legacy Request
Telephone
Web
80%
70%
60%
50%
40%
30%
20%
10%
0%
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14


% Top 4 YTD Categories of Journeys
Outpatient
Dialysis
Discharge
Oncology Patient
55%
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14

APPENDIX 2 - KEY PERFORMANCE INDICATORS

- Patients travelling less than 10 miles should not spend more than 60 minutes on any one journey

- Patients travelling between 10 and 35 miles should not spend more than 90 minutes on any one journey

- Patients travelling between 35 and 50 miles should not spend more than 120 minutes on any one journey

- Arrival within 45 minutes before, to 15 minutes after, booked arrival time

- Where booked prior to the day of travel, patients not to wait more than 60 minutes for their (outbound) journey

- Where booked on the day of travel, patients not to wait more than 4 hours for their (outbound) journey (within two hours for end of life patients)

- Percentage of journeys cancelled by ATSL

- Percentage of journey collections missed (aborted journeys)

- Percentage of in-bound calls to ATSL call centre answered within 30 seconds

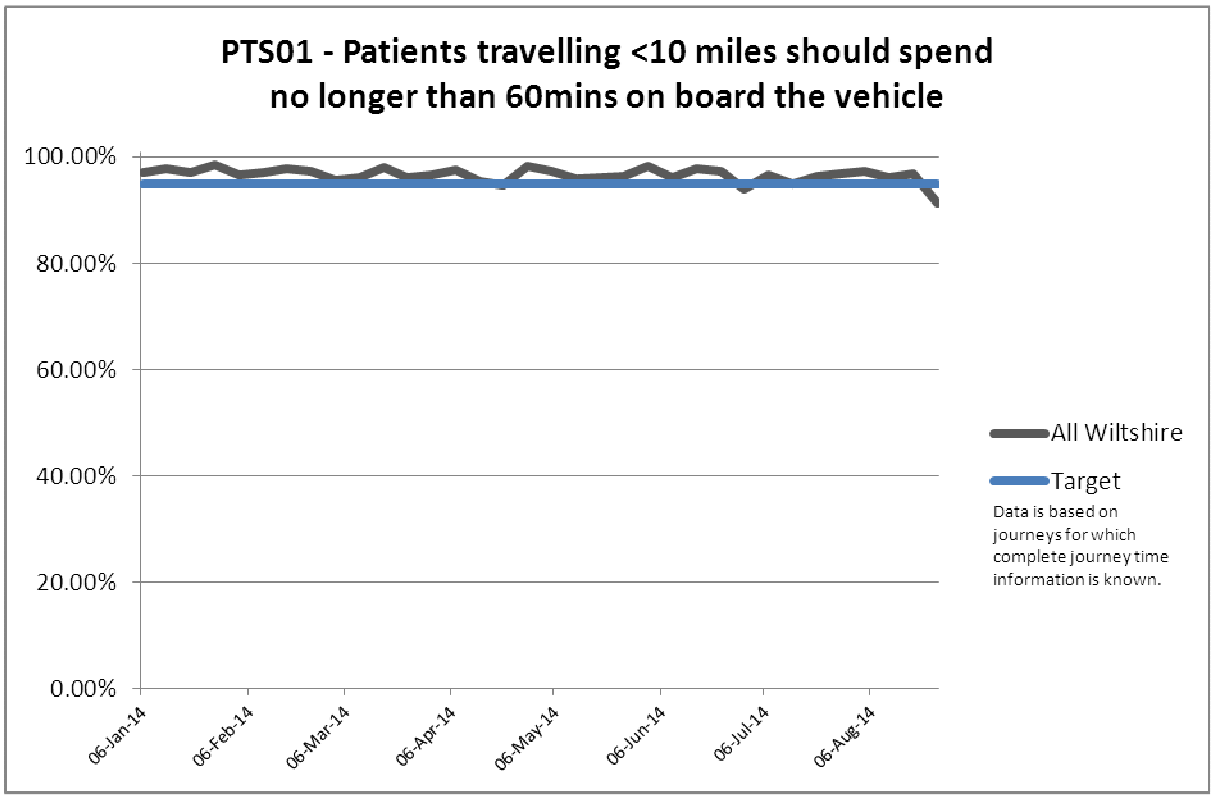
- Percentage of complaints acknowledged within one working day

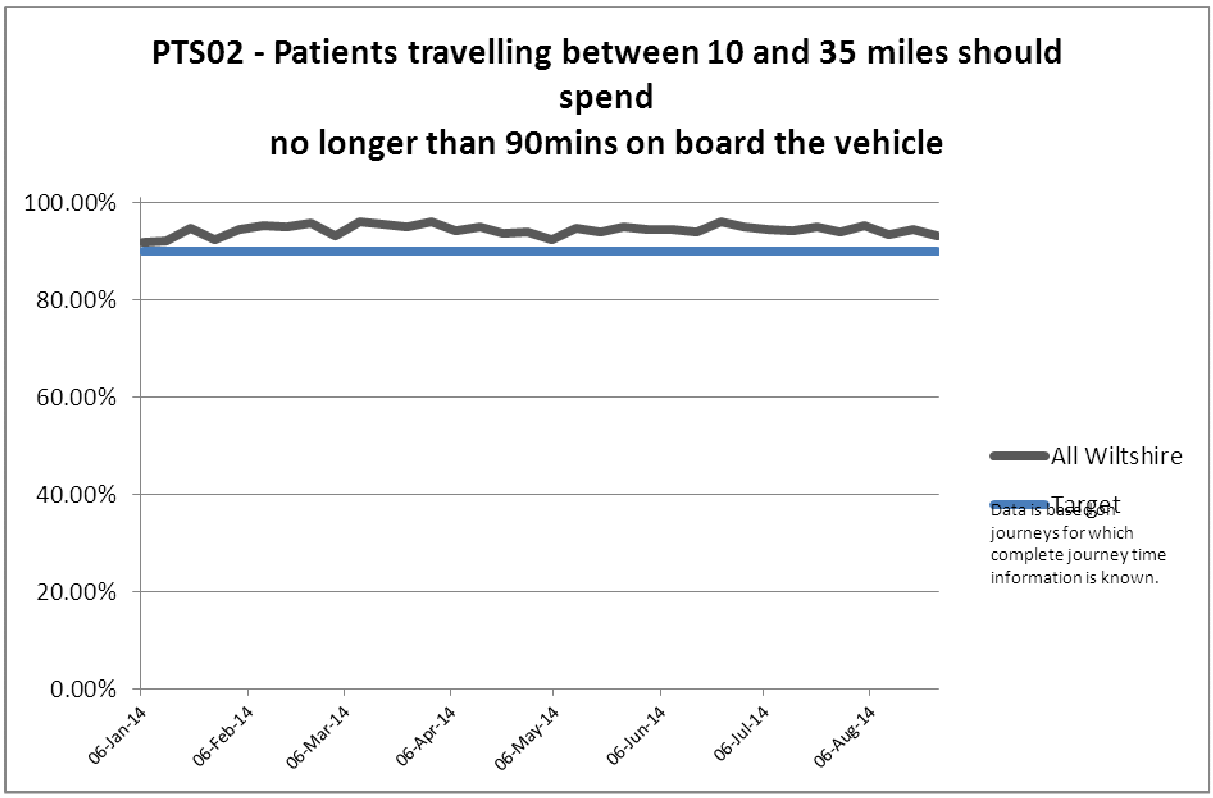
- Compliance with agreed complaints procedure (full response within 25 days)

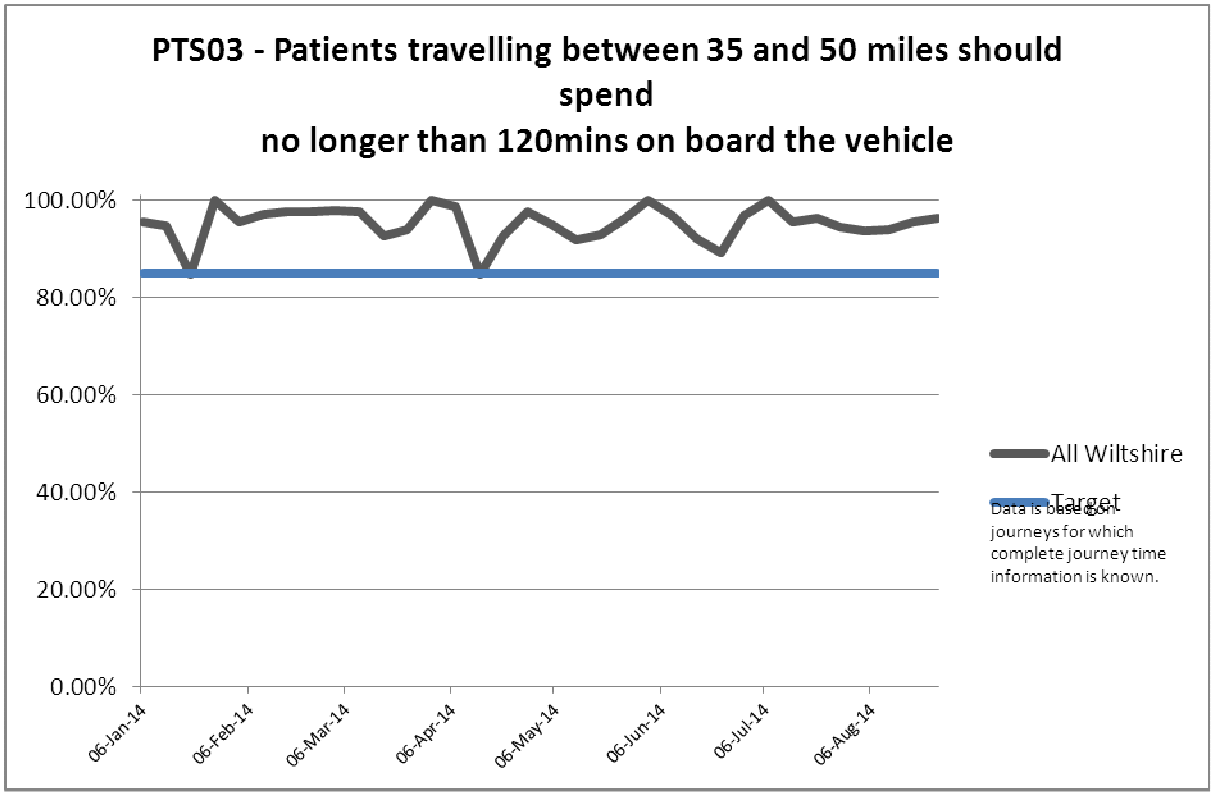
- Availability of on-line booking system

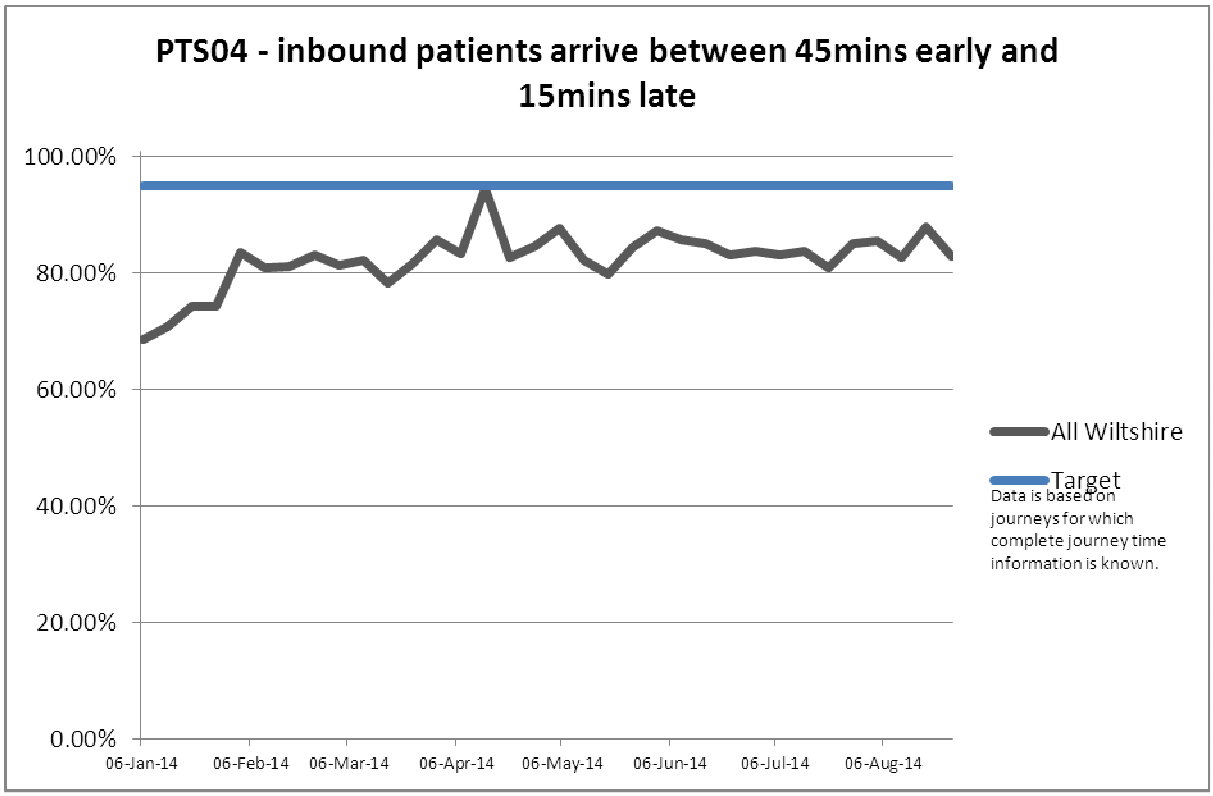
- Availability of telephone booking system

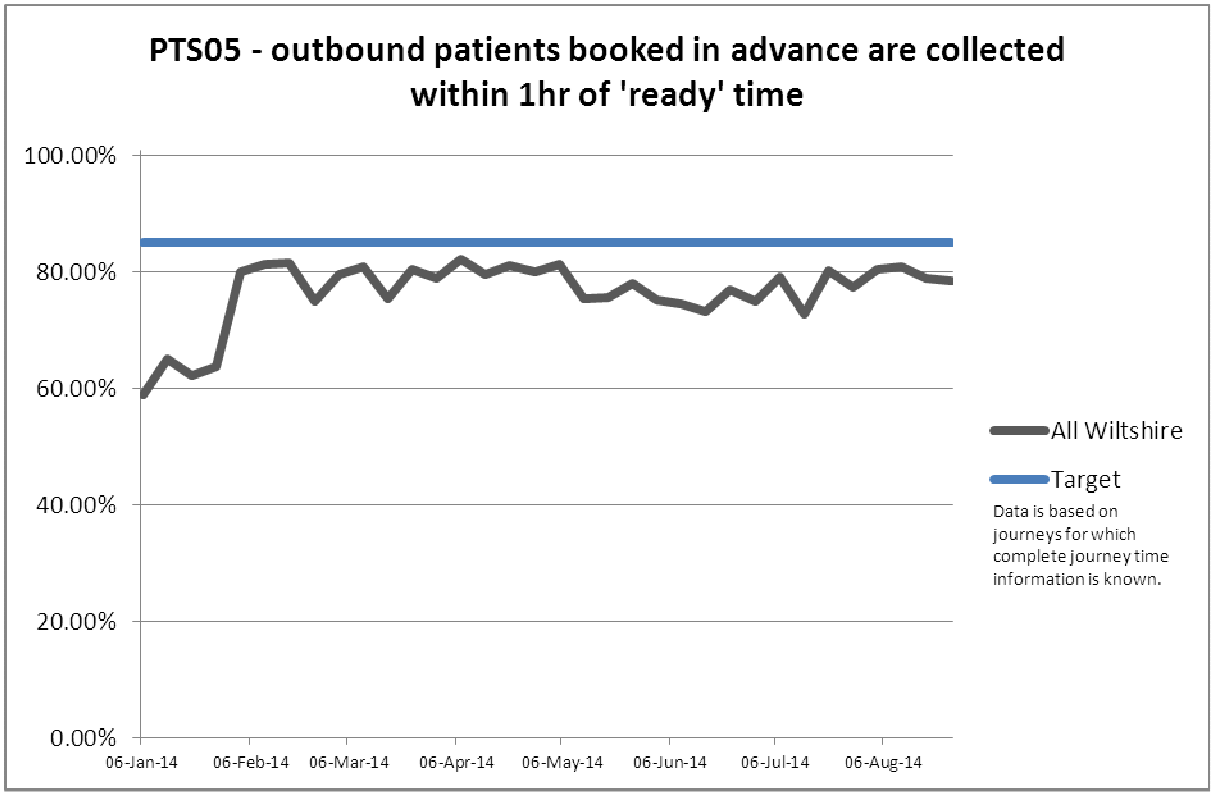
Performance charts for KPI's 1-6, which relate to patient experience and specifically timeliness, are included for the period Jan-Sep 2014. December is excluded: it was the initial month of the contract, and there was an understandable degree of turbulence that meant it was not truly a representative month of activity.

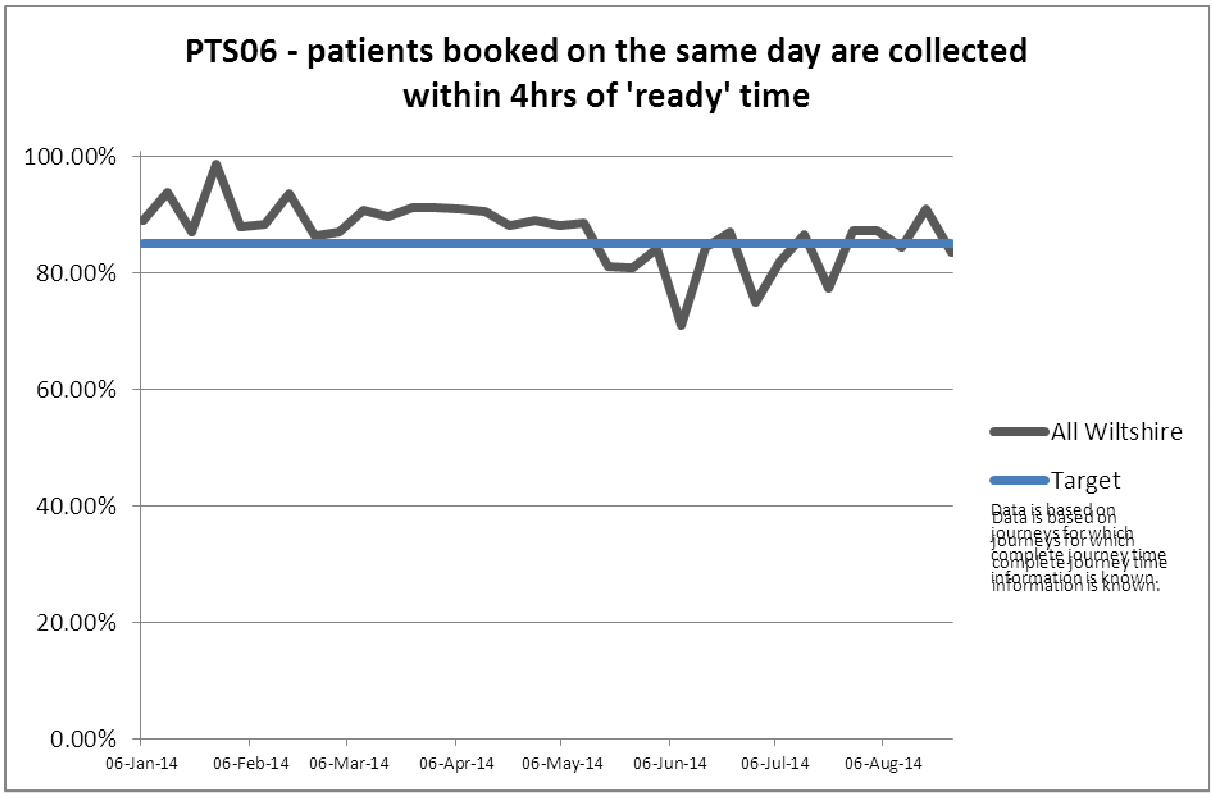

PTS01 - Patients travelling <10 miles should spend no longer than 60mins on board the vehicle
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
06-Jan-14
06-Feb-14
06-Mar-14
06-Apr-14
06-May-14
06-Jun-14
06-Jul-14
06-Aug-14
All Wiltshire
Target
Data is based on journeys for which complete journey time information is known.

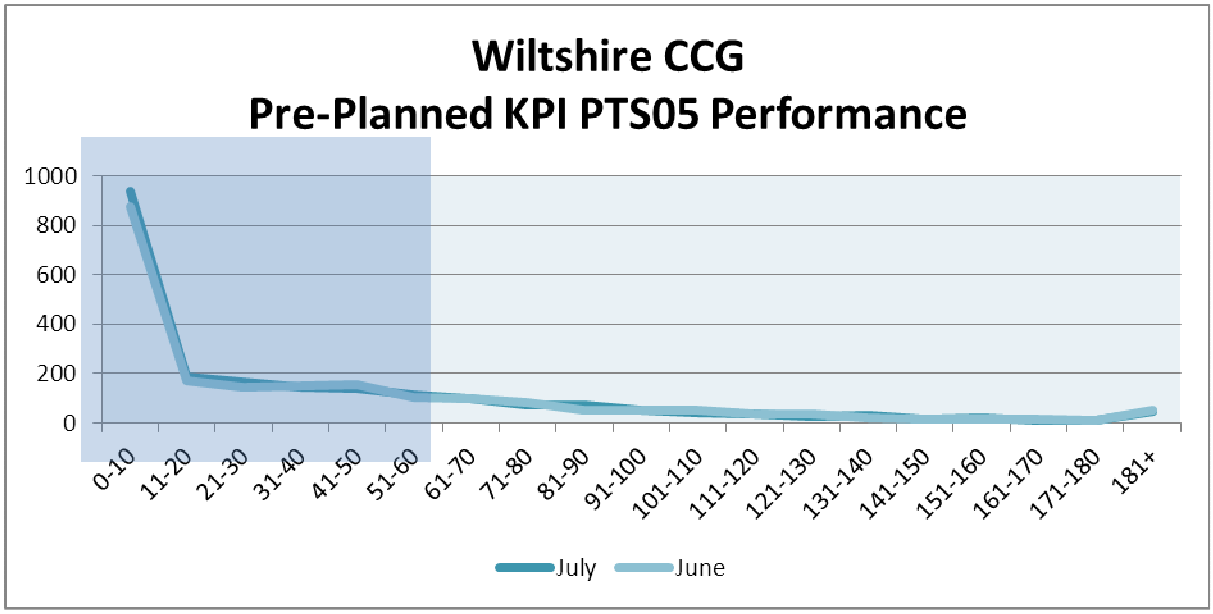

PTS02 - Patients travelling between 10 and 35 miles should spend no longer than 90mins on board the vehicle
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
06-Jan-14
06-Feb-14
06-Mar-14
06-Apr-14
06-May-14
06-Jun-14
06-Jul-14
06-Aug-14
All Wiltshire
Target
Data is based on journeys for which complete journey time information is known.


PTS03 - Patients travelling between 35 and 50 miles should spend
no longer than 120mins on board the vehicle
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
06-Jan-14
06-Feb-14
06-Mar-14
06-Apr-14
06-May-14
06-Jun-14
06-Jul-14
06-Aug-14
All Wiltshire
Target
Data is based on journeys for which complete journey time information is known.

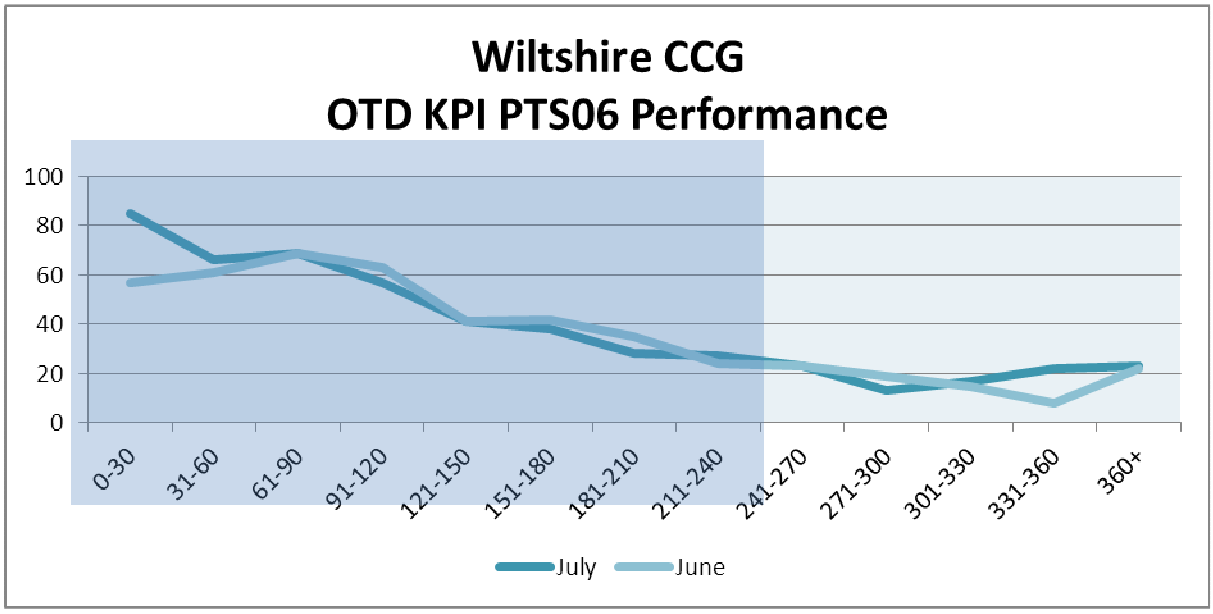

PTS04 - inbound patients arrive between 45mins early and 15mins late
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
06-Jan-14
06-Feb-14
06-Mar-14
06-Apr-14
06-May-14
06-Jun-14
06-Jul-14
06-Aug-14
All Wiltshire
Target
Data is based on journeys for which complete journey time information is known.


PTS05 - outbound patients booked in advance are collected within 1hr of 'ready' time
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
06-Jan-14
06-Feb-14
06-Mar-14
06-Apr-14
06-May-14
06-Jun-14
06-Jul-14
06-Aug-14
All Wiltshire
Target
Data is based on journeys for which complete journey time information is known.

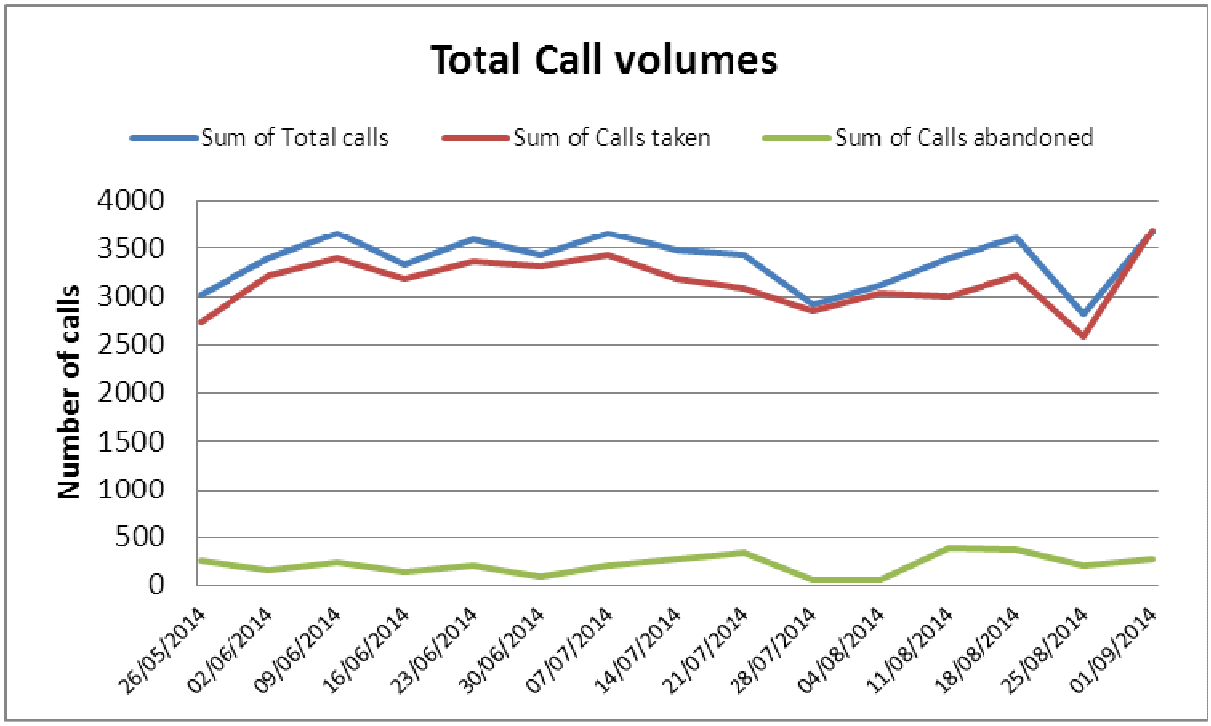

PTS06 - patients booked on the same day are collected within 4hrs of 'ready' time
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
06-Jan-14
06-Feb-14
06-Mar-14
06-Apr-14
06-May-14
06-Jun-14
06-Jul-14
06-Aug-14
All Wiltshire
Target
Data is based on journeys for which complete journey time information is known.



0-60 minutes	61-90	91-120	121-150	151-180	181+
76.25%	10.79%	5.85%	3.31%	1.59%	2.22%



0-60 minutes	61-120	121-180	181-240	241-300	301-360	361+
29.67%	24.75%	15.52%	10.81%	7.07%	7.66%	4.52%


Total Call volumes
Sum of Total calls
Sum of Calls taken
Sum of Calls abandoned
Number of calls
4000
3500
3000
2500
2000
1500
1000
500
0
25/05/2014
02/06/2014
09/06/2014
16/06/2014
23/06/2014
30/06/2014
07/07/2014
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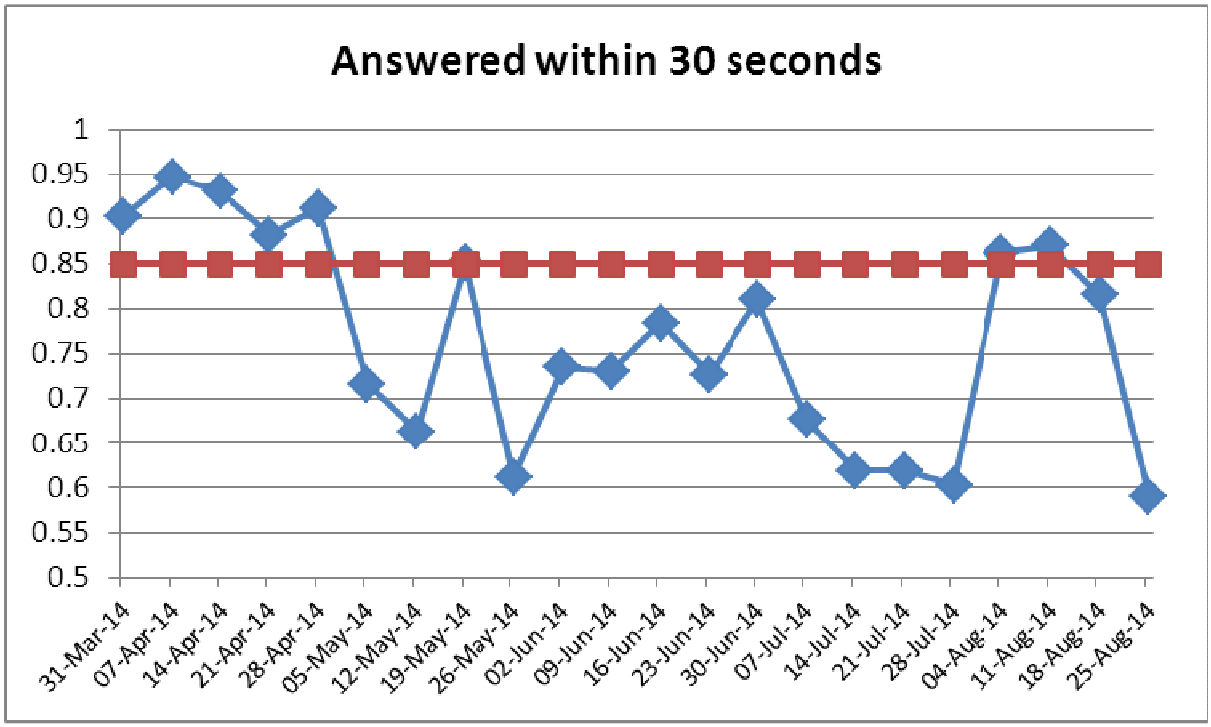
28/07/2014
04/08/2014
11/08/2014
18/08/2014
25/08/2014
01/09/2014


Answered within 30 seconds
1
0.95
0.9
0.85
0.8
0.75
0.7
0.65
0.6
0.55
0.5
31-Mar-14
07-Apr-14
14-Apr-14
21-Apr-14
28-Apr-14
05-May-14
12-May-14
19-May-14
26-May-14
02-Jun-14
09-Jun-14
16-Jun-14
23-Jun-14
30-Jun-14
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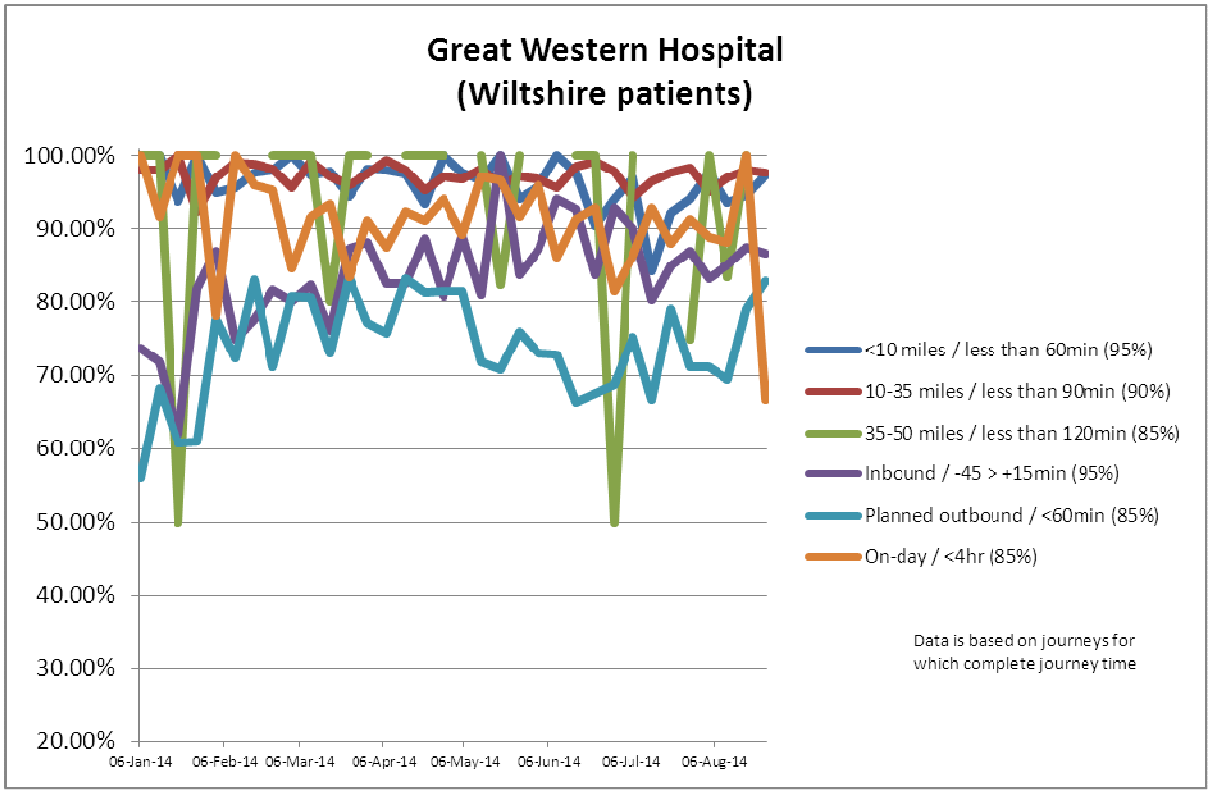
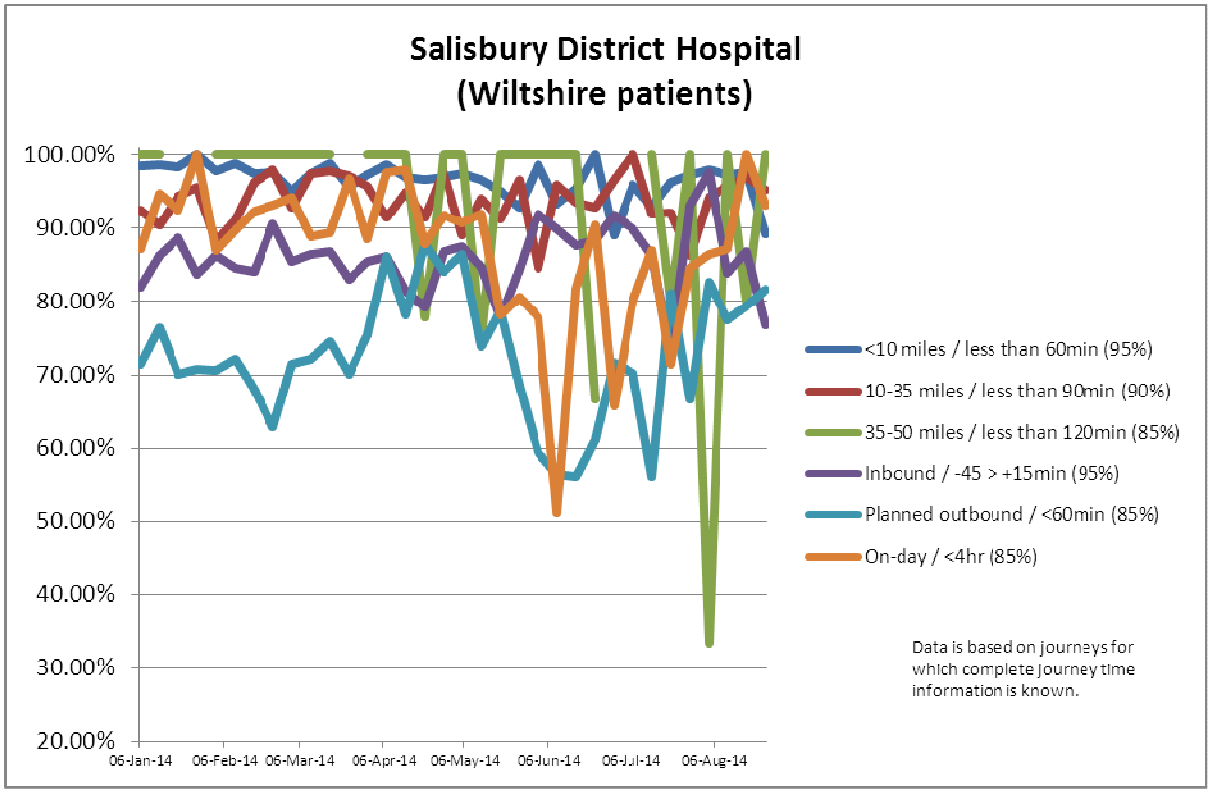
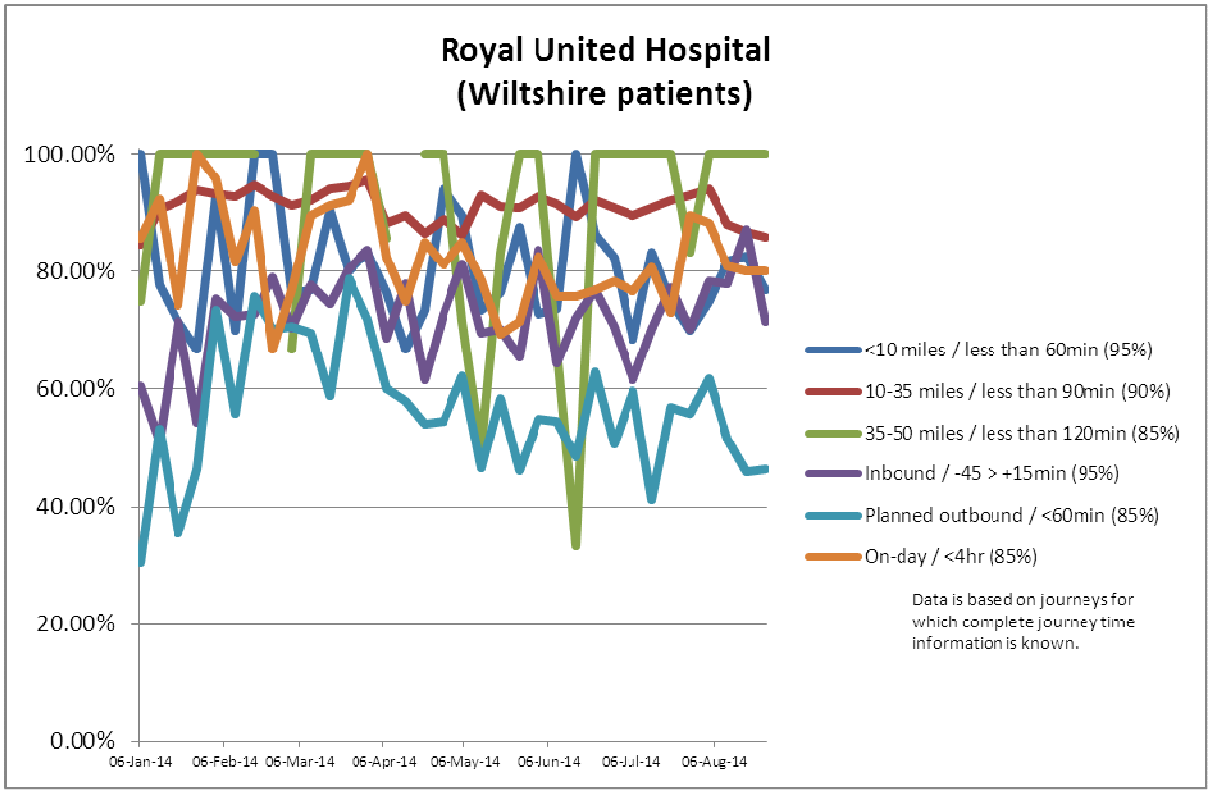
21-Jul-14
28-Jul-14
04-Aug-14
11-Aug-14
18-Aug-14
25-Aug-14


Great Western Hospital
(Wiltshire patients)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
06-Jan-14
06-Feb-14
06-Mar-14
06-Apr-14
06-May-14
06-Jun-14
06-Jul-14
06-Aug-14
<10 miles / less than 60min (95%)
10-35 miles / less than 90min (90%)
35-50 miles / less than 120min (85%)
Inbound / -45 > +15min (95%)
Planned outbound / <60min (85%)
On-day / <4hr (85%)
Data is based on journeys for which complete journey time


Salisbury District Hospital
(Wiltshire patients)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
06-Jan-14
06-Feb-14
06-Mar-14
06-Apr-14
06-May-14
06-Jun-14
06-Jul-14
06-Aug-14
<10 miles / less than 60min (95%)
10-35 miles / less than 90min (90%)
35-50 miles / less than 120min (85%)
Inbound / -45 > +15min (95%)
Planned outbound / <60min (85%)
On-day / <4hr (85%)
Data is based on journeys for which complete journey time information is known.


Royal United Hospital
(Wiltshire patients)
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
06-Jan-14
06-Feb-14
06-Mar-14
06-Apr-14
06-May-14
06-Jun-14
06-Jul-14
06-Aug-14
<10 miles / less than 60min (95%)
10-35 miles / less than 90min (90%)
35-50 miles / less than 120min (85%)
Inbound / -45 > +15min (95%)
Planned outbound / <60min (85%)
On-day / <4hr (85%)
Data is based on journeys for which complete journey time information is known.

Date: 11 September 2014

Subject: Mears Help to Live at Home Wiltshire

Authors: Alan Long, Mears Executive Director and
Bernadette Walsh, Mears Chief Operating Officer

1. Summary

1.1 Mears is a strong believer in the approach taken by Wiltshire Council to reshape services for the benefit of older and disabled people and to improve terms and conditions amongst the care workforce.

1.2 Despite having a 4 week mobilisation period in 2013, Mears delivered a very good service from contract start.

1.3 A good service continued to the point of acquiring some sub-contractors, notably Careline in May 2014. The impact of these acquisitions were to significantly de-stabilise, what had been a very good service.

1.4 We are leaving no stone unturned to get back to pre-acquisition service levels and are making progress. We are confident that with the continued support of Wiltshire Council, that this will be achieved.

2. Background

2.1 Mears were awarded the Help to Live at Home contract for the East and South regions of Wiltshire on 21/08/2013. After the termination of the previous contract, Mears agreed to support Wiltshire Council by mobilising in a four week time period. The contract started on 30/09/2013.

2.2 Services were TUPE'd and transitioned seamlessly from the outgoing provide Aster Living.

2.3 At the point of transfer there were:

- 470 service users
- 136 care workers
- 5,153 hours of care (3015 hours delivered by subcontractors)
- 15 subcontracting companies

2.4 Since being awarded the contract Mears has made significant improvements to service delivery including:

- An increase in the office and infrastructure staff from 14 to 38 team members.
- All care workers have been offered salaries, contracted hours and retainer payments.
- Training and support has been increased including a bespoke Help to Live at Home induction with Helen Sanderson personalisation training.
- Customer care initiatives have been delivered designed to tackle social isolation and loneliness.
- In January 2014, four months after contract start, Mears were the first provider to successfully pilot the new model of working in the Salisbury area in partnership with Age UK, Wiltshire Carer Support Network and the wider voluntary sector. It involved joint assessments of need and utilisation of the voluntary and support sectors to make the Help to Live at Home vision a reality.

3. Rationale for Acquisition

3.1 In April 2014 Mears were directly delivering 2125 hours of care (36%) but were subcontracting 3840 hours (64%). An integral part of Mears strategy in partnership with Wiltshire Council was to enhance the terms and conditions of care workers and ensure the workforce was built with career development and sustainability of service at its foundations.

3.2 Subcontractors supporting the contract with staff on zero hour contracts with no option for salaried work did not align to this strategy. There were further concerns about the quality of care delivered and sustainability of some parts of the subcontracted workforce. Officers from Wiltshire Council and Mears agreed that the acquisition of sub-contractors was important to drive forward improvements in the workforce.

3.3 Mears focused on those sub-contractors that wanted to sell. Wiltshire based domiciliary care company Careline had seen a previous attempt to sell the company collapse and they approached Mears to see if we would be interested in acquiring their business.

3.4 Following a 4 week period of due diligence incorporating operational, financial and legal scrutiny, Mears acquired Careline on 02/05/14.

3.5 At the point of acquisition there were:

- 38 service users
- 27 care workers
- 554 hours of care
- 2 office staff

3.5 Careline and its care workers operated in one of the most remote areas of the County. Many of the service users were on the Dorset borders. A number of care workers who had previously operated in these areas did not transfer. Replacing care workers willing to work in the most remote areas of Wiltshire is a significant challenge.

3.6 The former owner of Careline left the business on the day of completion 02/05/14. Despite a formal understanding that the registered manager and care coordinator would transfer to Mears, both left within a ten day period without giving any notice period.

3.7 Despite having a compliant CQC inspection report. Service user records were inaccurate and incomplete and the information upon acquisition failed to match the assurances made during the due diligence process.

3.8 In agreement with Council Officers, Mears also acquired:

Institu acquired on 15/05/2014
90 service users
59 care workers
900 hours of care

Agin Care acquired on 07/07/2014
41 service users
32 care workers
852 hours of care

4. Key issues:

4.1 In total 28 care workers did not transfer to Mears after acquisition. This placed additional pressures on Mears existing staff who have had to cover the shortfall and cover packages in the most remote areas of the County. This was further compounded due to some subcontractors having staff shortages of their own which resulted in them having to hand back existing work to Mears at very short notice.

5. Action Taken:

5.1 Mears are working hard to resolve the issues and have taken the following actions:

- Daily service progress reports produced for Wiltshire Council and CQC.
- Invested in dedicated IT support to align the IT packages of acquired companies to the CareFirst IT system.
- The South, the area where service delivery has been most challenging has been divided into South 1 and South 2.

- Invested in a dedicated Help to Live at Home Recruitment team, based in Amesbury with the purpose of recruiting new care workers.
- Employed two full time nurses to support customers with complex health needs.
- Designed and rolled out a programme of visits to service users and advocates to discuss care provision.
- Seconded staff from around the UK to deliver care, drive up service standards and support operational delivery .
- Provided service tags to all service users to enable electronic monitoring of the service.
- Initiated a programme of risk assessments and care plan reviews of all service users.
- Developed a partnership with YMCA to source 50 apprentices
- Substantial investment in the Care Management team and infrastructure taking the team from 22 posts in May 2014 to 38 posts in September 2014

5.2 Following a non-compliant CQC inspection report and receipt of notice of decision from CQC on the 03/09/14, no further referrals can be accepted by Mears until 30/11/14 by which time the service needs to be fully compliant with CQC and a further re-inspection of service will be undertaken.

6. Conclusion

6.1 Mears Help to Live at Home has the full backing of the Mears Board to support all additional investment required to return to the service levels previously achieved.

6.2 We are extremely sorry that some service users have seen their service deteriorate. We are already seeing signs of improvement and are dedicated to resolving the issues as quickly as possible.

Please do not hesitate to contact us if you have any questions or enquiries:
alan.long@mearsgroup.co.uk or bernadette.walsh@mearsgroup.co.uk

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ACTION PLAN FOR MEARS CARE
Wiltshire

6th August 2014

Provider name:	Mears Care Limited
Provider address:	Minton House Distribution Centre, London Road, Amesbury
Location of service:	Wiltshire

This Action Plan has been prepared in response to the CQC Review of Compliance Report written following a site inspection on the 20th June and 2nd July 2014 and the required Compliance Actions contained within it.

This Action Plan adopts a SMART approach, that is to say the plan is intended to provide a description of **S**pecific, **M**easurable, **A**chievable objectives which are both **R**ealistic and can be delivered in a **T**imely way..

The plan therefore outlines the areas where a need for improvement has been identified and provides a clear and practical course of action to be followed in order to address problems, issues and/or failings. Those involved in the implementation of these improvements are identified within the plan with indications of expected timelines. The Action Plan also provides a clear set of expectations in terms of how we will be able to evidence that improvements have been made.

Contents

Compliance Actions

Compliance Actions

Outcome: Care and welfare of people who use services

People should get safe and appropriate care that meets their needs and supports their rights

Failings identified in Compliance Report

1. Service users do not know what time the care workers will be completing allocated care visits, schedules of visits were not being sent out
2. Care calls are often late or missed – these missed or late visits were having significant impact on the wellbeing of service users
3. Communication with service users over late or missed calls is very poor
4. Continuity of care was poor for some service users
5. Male care workers were being sent to service users who had stated a preference for female care workers only
6. Communication with service users was poor to the point service users were experiencing anxiety over changes that were happening
7. Some double up visits were being completed by one care worker
8. A number of service users did not have adequate care plans in place for the care workers to refer to when providing care

Details of areas within the branch that need to improve – actions to be taken, what is to be achieved & who will be involved

Service users schedules:

- All service users schedules are being reviewed at the moment to look at times of calls, regular care worker allocation and tasks required.
- The staff plan rostering system is being used to record all service users' schedules.
- Service users are being allocated to set teams based on geographical locations, care workers are being allocated to teams along the same geographical boundaries to improve consistency of care and address issues with call times/travel times
- Service users schedules are being sent out periodically to update service users on planned visits
- Preferences are being updated on staff plan with regards to female/male only care workers etc., staff plan is set up to ensure that males can not be allocated to females who have declined male care workers etc.
- Regular written communication is being sent out to both care workers and service users updating them on the on going situation
- Visits are being undertaken with service users where written communication is not feasible, these visits are being used to update service users on changes and actions being taken to address this issues being reported

Missed visits:

- All service users are being provided with an electronic tab to be located in the front of their care folder, all care workers have been issued with a gen tag phone This system is used to log in to and out of care visits by care workers
- Once all tags have been issued an electronic call monitoring system will be used to monitor arrival times of care workers, where no arrival time is logged an alarm will be generated and action can be taken to ensure that the call is completed and that the service users are updated over any changes or delays
- A missed call process has been put in place and issued to all staff – this provides clear guidance on how to manage a non attendance by care worker – this is monitored on a daily basis by the office staff
- All missed calls are reported to the local authority and investigated fully, where appropriate action is taken with staff who have failed to ensure that the care call is covered

Communication with service users:

- Regular written communication is being sent out to both care workers and service users updating them on the on going situation
- Visits are being undertaken with service users where written communication is not feasible, these visits are being used to update service users on changes and actions being taken to address this issues being reported

Continuity of Care:

- All service users' needs are being reviewed and where appropriate staff plan is being updated to ensure that preferences are fully recorded.
- A regular report is run to monitor continuity of care and where continuity of care falls below acceptable levels service users are being contacted to discuss what action needs to be taken.

Double up visits being completed single handed:

- Double up runs are being scheduled to ensure that all double up calls are allocated to consistent care workers at consistent times. The allocating of double up calls to the same team will ensure that both care worker arrive at the same time so all planned double ups are completed as per service users schedule.

Service User Care Plans:

- A visiting officer has been allocated to the task of ensuring that all service users have up to date and relevant paper work in their homes including care needs risk assessments, individual support plans, medication record charts and communication log books

Date by which time improvements will have been implemented

Actions to reduce missed and late visits are being taken with immediate effect. Significant improvement will be achieved by the week ending 8th August.

Longer term actions including rescheduling of South area will be completed by Monday 1st September 2014. This will include the confirmation of double runs as above, as well as regular, consistent scheduling of all care calls across the south area.

Service user schedules are already being sent out, this will continue on going.

The placement of service user tags will be completed by the 29th August 2014, at this point the alarms system will be fully implemented again with the aim of reducing late and missed visits.

All service users will receive a review visit over the coming 6 months. We will begin with priority service users where care needs are identified as high. In the meantime continuity of care will be monitored. All service users will have a Mears Care Care Needs Risk Assessment and Individual Support Plan in their home by January 2015.

The impact these changes will have on people who use our services

On full implementation of these measures all service users will receive a timely, effective and high quality service as per their agreed support plans. Other outcomes will be:

- Missed visits will be reduced to an absolute minimum
- Continuity of care will be improved for all service user
- All service users will be fully aware of on going plans regarding both their individual service provision but also the on going plans with Mears Care as a provider
- All care workers will be encouraged and supported to develop good working relationships with service users through consistency of care planning.

Outcome: Management of Medicines

People should be given the medicines they need when they need them and in a safe way

Failings identified in Compliance Report

1. Due to late and missed visits service users are not receiving medication as per their prescription and health needs.
2. Adequate medication records are not in place for all service users.
3. Staff were not always aware when support with medication was required
4. Although staff had been provided with a comprehensive copy of the medication policy and procedure on transfer to Mears, staff were reporting that this was not always being followed
5. Some staff reported that they were assisting with/administering eye drops with out adequate training and support

Details of areas within the branch that need to improve – actions to be taken, what is to be achieved & who will be involved

Late & Missed visits impacting on the administration of medications:

- All service users where support with medication is identified as part of their care provision will have this information recorded on the Staff Plan Rostering System and will be highlighted as high priority. This priority list will be provided to all care workers
- Where calls are uncovered all high priority service users will be allocated to care workers first, contact will be made with next of kin to advise of delay and where appropriate medical advice will be sought to assess the impact of any delay on the service user.
- To minimise the chance of a missed visit all service users are being provided with an electronic tab to be located in the front of their care folder, all care workers have been issued with a gen tag phone. This system is used to log in to and out of care visits by care workers. Once all tags have been issued an electronic call monitoring system will be used to monitor arrival times of care workers, where no arrival time is logged an alarm will be generated and action can be taken to ensure that the call is completed and that the service users are updated over any changes or delays
- A missed call process has been put in place and issued to all staff – this provides clear guidance on how to manage a non attendance by care worker – this is monitored on a daily basis by the office staff. This missed call procedure includes actions to be taken to manage any impact on medication due to a call being late or missed.

Adequate documentation in place to record support with medication:

- All care workers are being asked to report any service user who does not have adequate paper work in place
- All care workers are being provided with a supply of Medication Administration Records to keep with them for use as necessary
- All care workers' will be issued with a copy of the medication policy and procedure plus some guidance and reminders on do's and don'ts.
- All care workers will have a training session (class room or community based) on supporting service users with medication. Where appropriate this will include training support with eye drops etc.
- Once training and support has been provided spot checks and on site observations will also be completed to ensure that the training is being put in to practice.

Staff were not always aware when support with medication was required:

- A visiting officer has been allocated to the task of ensuring that all service users have up to date and relevant paper work in their homes including care needs risk assessments, individual support plans, medication record charts and communication log books
- Medication support will be recorded on staff plan ensuring that this information is

available to all staff at all times.
- Information about medication support will also be provided via the care worker rotas which is communicate via an electronic system on the care workers mobile phones

Training and support available to staff regarding support with medication:
- All care workers' will be issued with a copy of the medication policy and procedure plus some guidance and reminders on do's and don'ts.
- All care workers will have a training session (class room or community based) on supporting service users with medication. Where appropriate this will include training support with eye drops etc.
- Once training and support has been provided spot checks and on site observations will also be completed to ensure that the training is being put in to practice.

Date by which time improvements will have been implemented

All service provisions are being reviewed to identify where medication support is required, this exercise will be completed by Friday 22nd August 2014 and documentation will be issued to all care workers visiting these service users by Friday 29th August 2014. On going audits of medication records will begin immediately and continue on going.

All documentation to be issued to care worker with regards to do and don't will be completed by the week ending 15th August 2014. Ongoing spot checks and support with training will be planned in over the coming 4 weeks to ensure that all staff are offered access to support as identified.

The impact these changes will have on people who use our services

On full implementation of these measures all service users will receive a timely, effective and high quality service as per their agreed support plans. Other outcomes will be:
- Missed visits will be reduced to an absolute minimum and will no longer have an impact on service users medication regime
- Service users records will be comprehensive and provide a clear summary of support provided with medication
- Continuity of care will be improved for all service user ensuring that all care needs are met by the care workers including support with medications
- All service users will be fully aware of on going plans regarding both their individual service provision but also the on going plans with Mears Care as a provider and will have a clear understanding of what support can be provided with medication

Outcome: Supporting Workers

Staff should be properly trained and supervised, and have the chance to develop and improve their skills.

Failings identified in Warning Notice & Compliance Report

1. Staff stated that they were providing support for service users they were not familiar with without adequate information about their needs.
2. Staff leaving and on going staff sickness is having an impact on the remaining staff and is causing both stress and anxiety and a general feeling of frustration.
3. Staff have not received any training or support since their transfer from other agencies.
4. Staff have not received any form of formal supervision since their transfer from other agencies.

Details of areas within the branch that need to improve – actions to be taken, what is to be achieved & who will be involved

Staff support and information when working with new service users

- All service users will have a review and where appropriate updated records put in to their homes to ensure that care workers are fully aware of what care needs to be provided
- Improved level of information will be provided to care workers via their telephone rota's including the support that service users require with medication

Staff are being impacted on by high levels of sickness and staff turn over

- A fully comprehensive recruitment plan has been implemented with targeted recruitment for difficult areas/service user specific needs
- Attendance management process are being managed to address repeated sickness of care workers
- Support is being provided by other care branches to cover care worker sickness etc.

Staff have not received adequate training or support since their transfer:

- All staff will receive a recruitment/retention phone call from a manager to review their current workload, training and support needs
- Based on the information received, training and support needs will be planned in and addressed as appropriate
- All staff who have transferred over from other agencies will receive target training sessions (classroom or community based) on support with medication, moving and handling and safeguarding vulnerable adults
- All staff will be provided with regular updates and information on policies and procedures, processes and any changes that are happening etc.
- Regular open days are being planned to attract new care workers but to also provide support to existing care workers, all care workers will be provided with dates for these on going open days and supported to attend
- Formal supervision sessions including appraisals will be planned in over the next three months – these will be one on one office based supervision sessions.

Date by which time improvements will have been implemented

Care workers meetings commenced the week of 28th July 2014 and have been happening on a weekly basis. This will continue over the coming months. All care workers are also receiving regular recruitment and retention calls over the coming weeks and will be completed by the week ending 29th August 2014.

All staff will receive an appraisal by the end of October 2014.

Updates on policies and procedures will be on going as will the regular open days and on site support.

The impact these changes will have on people who use our services

On full implementation of these measures all care workers will receive the training and support needed to provide a quality service and feel confident and happy in their roles as care workers. Other outcomes will be:

- All care workers will have a minimum of 4 supervision sessions over every 12 months
- All care workers will have regular contact with their direct line manager as well as office managers
- All care workers will receive the training and support they need to provide a safe and quality service
- All care workers will be encouraged to develop their skills and knowledge and as able progress with in the company

Outcome: Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.

Failings identified in Warning Notice & Compliance Report

1. People felt that they were not given the opportunity to provide feed back/share their views about the changes to the agency and that they were not formally asked about how their care provision was progressing
2. Staff felt that they were not adequately supported through on site observations and were not receiving feed back about their performance

Details of areas within the branch that need to improve – actions to be taken, what is to be achieved & who will be involved

Feed back and Sharing Views

- All service users are being contacted by the customer support team for a quality assurance check
- Concerns and feed back from these checks will be collated and actioned as appropriate
- This exercise will be completed at least 6 monthly
- All service users will also be offered the opportunity to participate in a program of service user engagement over the coming months – this will initially be targeted at service users who have received below standard care over the past weeks and will be gradually rolled out across the areas over the coming months.
- All care workers are being offered the opportunity to meet one on one with senior management to address any concerns
- All care workers are being offered the opportunity to attend regular open days and open evening to meet new staff and to discuss any on going concerns or issues
- All care workers' will receive a survey over the coming weeks that they can return anonymously should they not feel comfortable attending any of the above events

Support and feed back to staff:

- All care workers are being offered the opportunity to meet one on one with senior management to address any concerns
- All care workers are being offered the opportunity to attend regular open days and open evening to meet new staff and to discuss any on going concerns or issues
- All care workers' will receive a survey over the coming weeks that they can return anonymously should they not feel comfortable attending any of the above events
- All care workers will receive at least one on site observation every 6 months
- All care workers will be provided with regular feed back on performance through the above meetings etc.
- All care workers will be sent copies of any complements/concerns raised over their practice (where appropriate) with a letter of thanks attached etc.

Date by which time improvements will have been implemented

All service users are currently being contacted by the Customer Service Team, either via telephone or via a home visit, to discuss the recent changes and to gather feed back on service provision , this is on going and is expected to be completed by the end of September 2014.

On going surveys will be completed monthly with service users either via telephone or post over the coming weeks and a further postal survey will be sent out in 6 months time to review progress made.

All care workers will receive a postal survey by the end of August 2014 and will be invited to all on going open days etc via text message and invites.

A program of on site observations and supervsions will be planned in by the 8th August 2014 with a view to complete at least one on site observation/supervision session by the end of November 2014. On going a program of 4 supervision sessions will be planned in for all care workers.

The impact these changes will have on people who use our services

On full implementation of these measures all service users and care workers will be fully engaged in their interactions with Mears and will be consulted regularly regarding performance and quality issues.

Outcome: Complaints

People should have their complaints listened to and acted on properly

Failings identified in Warning Notice & Compliance Report

1. Not all service users are aware of how to make a complaint
2. Not all service users have the correct contact details for the office and on call service
3. Complaints are not being dealt with consistently and service user satisfaction with the outcome of complaints is variable
4. Service users relatives and next of kin contacts are not always aware of contact details for the office or how to report concerns

Details of areas within the branch that need to improve – actions to be taken, what is to be achieved & who will be involved

Service users are not aware of how to make a complaint:

- All service users and their next of kin will be sent an updated copy of Mears Service User Guide and Statement of purpose which includes advice on how to make a complaint including contact details for office and relevant staff members etc.
- All service users will be reminded of their right to make a complaint and contact details etc. at review visits, quality visits etc.

Complaints are not dealt with consistently:

- All office staff will receive a basic how to guide on how to manage and process any complaints
- All complaints will be dealt with by a dedicated office team member who will be responsible for managing all complaints received

Date by which time improvements will have been implemented

All service users will receive a copy of the Mears Statement of Purpose and Service User Guide by the 15th August 2014. Where relevant all service users next of kin etc. will also be provided with this documentation by the end of the week of the 15th August 2014.

Complaints are being passed with immediate effect to a dedicated office manager for auctioning and are on going. All complaints will be acknowledged with in 2 working days of the complaint being received and all complaints will be concluded with in 28 working days of complaint being received. Where this is not possible all complainants will be updated with reasons for the delays and a new agreed time frame.

All office staff will be issued with a guide on managing complaints by the 15th August 2014 and will receive office based support to manage complaints on going over the coming weeks.

The impact these changes will have on people who use our services

On full implementation of these measures all service users will feel confident in raising concerns and that these concerns will be dealt with appropriately and in a timely manner. Other outcomes will be:

- All complaints will be dealt with effectively
- All complaints will be fully documented and reviewed
- A regular analysis of trends will be completed and where appropriate action will be taken to address any system issues impacting on care etc.

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Westbury Court

Station Road, Westbury, BA13 3JD

Tel: 01373825002

Date of Inspection: 10 July 2014

Date of Publication: August 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Management of medicines	✖ Action needed
Staffing	✖ Action needed
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Laudcare Limited
Registered Manager	Mrs Christine Bassett
Overview of the service	Westbury Court is a purpose built nursing home, registered to accommodate 60 people. The home provides care for people with varied needs. Some people may be living with varying types and degrees of dementia and some people may require nursing care. The home is close to the town centre of Westbury.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 10 July 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We talked with other authorities.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

Two inspectors and an expert by experience visited the home and answered our five questions, Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

Below is a summary of what we found. The summary is based on our observations during the inspection. We spoke with 18 people using the service, eight relatives or friends, 12 of the staff supporting them, the manager and the regional operations manager. We looked at eleven care plans in detail or partially. Additionally we used the Short Observational Framework for Inspection (SOFI) for a forty minute period.

Is the service safe?

Care plans instructed staff how to meet people's needs in a way which minimised risk for the individual. However there was no evidence to show that these were followed. We found that daily records had not been completed consistently and care plans were not always up-dated to reflect people's current needs. This put people at risk of not being cared for in the best and safest way.

Mental Capacity Act (2005) assessments were included in plans of care. Assessments had been completed by care staff who had not completed Mental Capacity Act training. We saw that a best interest decision, which could involve restraint, had been made by an

individual carer. This meant that the decision made may not be appropriate.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the home liaised effectively with the local authority DoLS team and had, generally, made applications as appropriate. The home had made two DoLS referrals in 2014.

The home did not have any behavioural guidelines to support people with behaviours which could cause themselves or others distress. This put people at risk of not being supported safely during periods of difficult behaviour. We found that unexplained injuries or bruising were not investigated and it was not clear what action if any had been taken to minimise the risk of recurrence. People told us they felt they were: "very safe" living in the home. One person said: "there is no poor treatment, no abuse, it's not a bad place to live".

The home did not administer people's medication safely. We found that medication trolleys were left unlocked where people could access them. Medication was not always given at the prescribed times to allow safe timeframes between doses. This meant that people in the home may not be safe from harm caused by medication.

We found that there were not enough staff (or they were not effectively deployed) to meet people's needs. Call bells were not answered in a timely way which put people at risk of harm. The majority of people told us that there were not enough staff around but others told us: "There are always enough staff".

Health and safety was taken seriously by the home and all the appropriate safety checks had been completed. This reduced the risks to people and helped the service to continually improve.

Is the service effective?

Plans of care were not reviewed regularly and it was not clear if any necessary changes had been made to them. This meant that the care being given may have been out of date or inappropriate for the individual's current needs. It was unclear how people were identified as requiring 'nursing' or 'residential care'. People who were 'residential' care had their health care needs met by district nurses or community health professionals. This meant that people sometimes had to wait for paramedics to arrive for simple procedures such as the application of dressings.

People's individual well-being records were not completed accurately. They did not include 'targets' such as how much an individual should drink for staff to know if the individual was at risk of dehydration and of the action to take. The pressure setting of specialist mattresses used to promote individuals pressure care was not detailed for staff to monitor effectively. This meant that people may be at risk of harm because staff were not aware of how to ensure their well-being.

People told us they were happy with the care they received and felt their needs were met. One person told us they were going to an outpatient appointment they said: "the home has arranged a taxi and one of the nurses is going with me. It's lovely; I don't have to worry at all". However, some relatives told us they were concerned that their relatives care needs were not met in a timely manner.

Is the service caring?

People were supported by some staff who were mostly patient, kind and responsive. People who lived in the home told us staff were ""very nice, anything you want they do, they are not bad at all". Another told us how: "excellent" staff were when they helped them after a fall. However we observed that people were not always responded to in a timely manner when calling for assistance. Our observations found that some staff had not responded in a professional and caring manner. Examples included negative responses we overheard from staff when people had repeatedly asked for a drink, such as: "Oh dear everyone would think you were never fed and watered". Some people's requests during the lunch time meal had been ignored.

We found that care and support had not always been provided in line with people's preferences and wishes. An example included a person who wanted to get up in the morning still being in bed at 2.30 pm. One person said, "you get fed up being in bed". They told us that they weren't sure if it was their choice to stay in bed but didn't think so because they hadn't been up much.

Is the service responsive?

Staff did not always respond to people's needs and requests in a timely way. We observed people calling out for help with little to no response. Care plans were not always amended as people's needs changed.

It was not always clear that the home had acted on the learning gained from accidents, incidents and complaints. They did not respond to advice from other professionals such as the pharmacist. We saw that pharmacist had visited in October 2014. They had made two recommendations which had not been actioned.

The home had various ways of listening to the ideas and opinions of the people who lived in the home and their relatives and friends. They had made some changes and improvements as a result of ideas and discussions with people who live in the home and their relatives.

Is the service well-led?

The regional manager told us that the registered manager had left her post in May 2014. We had not received a registration cancellation application from them. An interim manager was in post until the permanent manager was appointed on 2 July 2014. Staff told us it: "feels like months since a manager was in place". Some told us: "Things have gone down-hill since the manager left" (referring to the last registered manager).

Staff told us they were clear about their roles and responsibilities. Most of the staff we spoke with told us there were not enough staff to meet the needs of the people who lived in the home. They told us they felt unsupported, staff morale was low and that they did not always work well as a team. Some staff told us that they had no confidence in the management of the home. There were high levels of staff sickness in the home.

The service had a comprehensive quality assurance system. However, the system had not identified shortfalls in important areas of the quality of the care being given. As a result the quality of the service was not being maintained or improved.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 21 August 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found that people's needs were assessed prior to or when people were admitted to the home. However, care and treatment was not planned and delivered in line with their individual care plan. We looked at four full care plans and seven daily care plans (kept in people's bedrooms). The information in the full care plans and the daily care plans was not always accurate. An example included a person's mobility not being noted as an issue on a care plan when the individual had recently sustained a fracture as the result of a fall.

We saw that the full care plans were detailed and clearly identified people's needs and the actions that needed to be taken to meet those needs. However, daily notes did not show that the individuals' needs were met in the way described. For the four people whose care we tracked in detail we found daily entries had not been made consistently. An example was a gap of 10 days in one person's daily record called 'my journal'. The provider may find it useful to note that the complex system of daily recording made it difficult to 'track' the care that had been provided.

The four plans of care we looked at had not been regularly reviewed during 2014 and it was not clear if any necessary changes had been made. Examples included assessments for mobility that were not up-dated when people returned from hospital. Nutritional assessments were not up-dated when people lost large amounts of weight in a short time frame.

We found that care and treatment was not planned and delivered in a way that ensured people's health, safety and welfare. There was a 'whiteboard' in the nurse's station on the ground floor which noted which charts needed to be completed in which rooms. This information was not dated but did not reflect the current situation. The manager told us they were not aware of this and corrected it during the course of the day. We saw that

daily plans of care, which included health and well-being charts, were not completed accurately. Examples included food and drinks charts which did not cross reference accurately with fluid charts and turning charts that should have been completed three hourly but which contained six hour gaps. Fluid and food charts did not contain 'targets'. Staff could not see how much people needed to eat and drink and what action to take if they did not have the required sustenance. We saw that during a 10 day period one person's food and drink chart had been completed from three to eight times a day. Staff told us that there should be at least six entries a day. A carer told us that one person, whose fluid intake records had not been completed accurately, had been diagnosed as dehydrated by the emergency services who were transporting them to hospital. we were unable to confirm this at the time of the inspection. However, the deputy informed us after the inspection that the hospital admission was due to loose stools caused by medication, which had resulted in dehydration.

Health care records were kept and included referrals to external professionals such as GPs, district nurses and tissue viability nurses. District nurses looked after the health care needs of people who were not identified as requiring 'nursing' care. A paramedic was called to apply a dressing to a person's leg because they were 'residential'. As it was out of hours a district nurse was not available. The criteria used to identify those people who required 'residential' and those who required 'nursing' care was not clear. The manager and area manager told us it depended on people's needs and staff told us it depended on the complexity of people's medication. There was confusion about carers and nurses responsibilities and there was no clear path for residential people requiring nursing intervention. This meant that we could not be sure that their needs were met as quickly and effectively as they should be.

We used the Short Observational Framework for Inspection (SOFI) tool for forty minutes during the lunchtime period. We specifically observed five people in the dining room on the first floor. We saw some staff responding appropriately to people's needs. Three staff did not respond in a timely manner to people who needed but did not ask for assistance. We noted that it was thirty minutes before one person was offered help to cut their food up. Some staff were positive and encouraging but some did not listen or respond to people's requests. For example people who requested gravy at the beginning of the meal, repeated the request for twenty minutes. Staff did not respond and as a consequence some people left most of their food. Staff removed almost full plates without asking why people had not eaten or offering them alternative food. We saw that some staff talked among themselves and did not include people in conversations.

In addition to using SOFI we observed meals being given to four people on the first floor. We saw that two people were encouraged to eat by an ancillary staff member, who was cleaning rooms. A third person was assisted by a member of care staff, we noted there was very little spoken interaction between a the staff member and the person they were feeding. We noted that another person's meal was taken away uneaten after approximately five minutes when they had not had any help or encouragement to eat it. Additionally we observed meals being given to four people on the ground floor. Carers were positive and encouraging during the meal service.

17 of the 18 people we spoke with told us that generally they were happy living in the home and with the standard of care they received. One person told us: "the home has arranged a taxi and one of the nurses is going with me. It's lovely; I don't have to worry at all" (for an outpatient appointment). Another person said sometimes, one of the senior carers will ask if there is anything extra they need help with during the day. One person

described how: "excellent" staff were when they helped them after a fall. Relatives and friends of people told us that they were generally happy with the standard of care people received. Some friends or relatives gave us examples of how people's physical appearance had improved since admission to the home. However, two relatives told us they had to take steps to ensure their relatives personal care needs were met. They said: "We were very upset a few weeks ago and had to step in to help my relative with personal care" and "Once or twice (referring to their relative) their hygiene needs were not met."

People who used the service would only be deprived of their liberty when this had been authorised by the Court of Protection or by a supervisory body under the deprivation of liberty safeguards (DoLS). The home had made two DoLS referrals in 2014.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who used the service were not protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were comprehensive safeguarding policies and procedures, including whistle blowing, available in the home. We saw that training records showed that 46 of the 58 staff had received safeguarding training. Staff told us that safeguarding training was not part of the induction process. This meant that some staff may not have been able to recognise or appropriately report possible abuse.Safeguarding training was repeated via e-learning every year, to ensure all staff were kept up-to-date with policies and procedures. We noted that some of the up-dates had not been completed. This meant that staff may not be aware of the latest information regarding safeguarding procedures. The four staff we spoke with about safeguarding had a clear understanding of their responsibilities with regard to protecting the people in their care. They described how they would deal with a safeguarding issue, including reporting issues outside of the organisation, if necessary. People told us they felt they were: "very safe" living in the home. One person said: "there is no poor treatment, no abuse, it's not a bad place to live".

People who used the service were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent it from happening. We looked at four plans of care, two noted unexplained injuries such as severe bruising to an eye and deep skin flaps. Photographs were taken of any injuries and falls and accidents were recorded. However, body maps were not always completed and records did not include an investigation of how the injury had occurred. There were no records to show that anyone had looked into how the bruising or lacerations could have occurred or taken any steps to minimise the risk of recurrence. We saw that some unexplained bruising was noted on the computer system. These records did not include any information with regard to investigations.

Specialist mattresses to minimise the risk of pressures sores were provided. The pressure setting of the mattresses was checked daily. However, there was no guide of what level the mattress should be inflated to for the individual using it. Staff therefore noted the air pressure but it was not clear if it was at the correct setting to promote the individual's

pressure care.

Mental Capacity Act assessments were included in all plans of care. They were an integral part of each specific care plan such as emotional well-being and communication. The assessments were completed by care staff. Training records showed that care staff had not completed Mental Capacity Act training. Staff spoken with confirmed that they had not received this training. We saw a best interests decision that had been made for an individual. This decision involved the potential use of restraint to assist the individual with personal care. This had been made by an individual carer, there was no reference to a multi-disciplinary meeting or discussion with the individual or advocates.

The home did not, generally, offer a service to people whose behaviour may cause themselves or others harm or distress. However, if people did develop long or short term behaviours that were distressing, the home referred them to a community psychiatric nurse. There were no behaviour plans for staff to follow to support people to control difficult behaviours, in those incidences.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider was not ensuring that the appropriate arrangements to manage medicines safely were being followed by staff.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found that there were appropriate arrangements for obtaining and recording medicines. The home used a monitored dosage system (MDS). This meant that each dose of medication had been prepared by the pharmacy and sealed into packs. People's medicines were prescribed by their GP and dispensed by the supplying pharmacist. Topical, liquid and controlled drugs were not dispensed within the MDS packs. These were recorded on the Medication Administration Record (MAR) for each person. One of the registered nurses showed us the schedule for reviewing and ordering the 28 day cycle of medicines. We saw that all prescribed medicine was ordered and were available for people to have as intended by their GP. Medicines that included medicines in boxes were counted as part of the homes quality monitoring process.

Arrangements were in place in relation to the recording of medicine. However, not all records were accurate or up-to-date.We looked at the Medicines Administration Records (MAR) for four people and found their medicine had been signed as administered. Prescribed creams (topical medicine) were not signed for. The MAR referred these to a Topical Medicines Application Record (TMAR). The TMAR was kept in individual's room for staff to sign once they had applied the person's prescribed cream. People's topical medication records were not complete. The TMAR of two people indicated they were not being administered topical medication as prescribed. One person's TMAR 26 June to 9 July 2014 indicated topical cream was administered once daily. This was as opposed to twice daily. Records showed that the person's topical medication had been reviewed by their GP and community nurse within this timeframe and were prescribed as twice daily. There were no written records to explain why the cream had not been applied. We observed there were several days between 26 June 2014 and 9 July 2014 where no recordings had been made. This meant that people's topical medicines may not have been administered as prescribed to promote the person's wellbeing.

When the medicine trolleys were not in use, medicines were kept safely. All medicines that included stock medicines were stored in locked cupboards or mobile medicine cabinets

within a secure room. The temperature of the medicine refrigerator was being recorded daily and was within the required temperature range. The medicine storage area had an air conditioning unit and records showed that the room was kept at a safe temperature. However, we observed the medication trolley was left open and unattended when staff were administering people's medication on the morning round. Some people who lived in the home lived with dementia. There was a risk that people could have taken medication from the unattended medicine trolley. This had placed people's welfare needs at risk of taking medicines that were not prescribed for them. We informed senior staff of our observation. Staff immediately took action to ensure medicine trolleys were not left unattended and that they were secure when left unattended. We have not been able to test that this compliance has been sustained.

The home had appropriate Controlled Drugs (CD) safes. CD storage is more secure than general medicines storage due to the increased risks. We checked the balance of the Controlled Drugs held in the CD safe against the register and these were in agreement.

Medicines were not safely administered. We observed people on the ground floor had received their medication within a reasonable timescale as prescribed. However, the administration of the morning medication to people on the second floor had taken three and half hours from 8:45 to 12:35. There were specific circumstances as to why the round had taken so long. However, this meant that some people may not have received their medication at the time they needed it. The time that medications were administered was not recorded on the MAR sheet. This meant that people were at risk of receiving unsafe dosages of medication. Additionally if a health problem arose staff would be unable to confirm at what time people had taken their medication.

At 14:00 we observed a member of staff administering people's medication, on the first floor. We established from our discussion with the staff member that they had started the afternoon medication round at 13:10. They told us they had administered medication to 13 people. This was approximately 35 minutes after the morning medication round had ended. This meant people were placed at risk of there not being enough time between medications or potential interactions between medicines being taken too close together. The member of staff told us that they had not received a handover at commencement of their shift due to covering staff absence. There were no records for the staff member to see to advise them that some people had received their medication late.The staff member immediately stopped administering people's medication and made safe the medication trolley. We spoke with the manager and informed them of our concern. We were later informed that the manager had contacted the prescribing GP to make sure people were safe due to the short time between the morning and afternoon administration of their medication.

The pharmacist visited the home to conduct and advisory inspection in October 2013 and made two recommendations. The home had not taken any action with regard to the recommendations. The regional manager told us via e-mail that the manager would now be completing an action plan to address all the recommendations.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled ,experienced or effectively deployed staff to meet people's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were not enough, effectively deployed, qualified, skilled and experienced staff to meet people's needs. The manager told us that minimum staffing ratios were eight (including one registered nurse) between 8am and 8pm. Minimum staffing during night time hours 8pm until 8am was one qualified nurse and five carers. The care staff were supported by an ancillary staff team which included a chef, domestics and maintenance personnel. We looked at rotas from 2 June to 6 July 2014. Rotas showed that the minimum staffing ratios were generally achieved although there were occasions when less than eight staff were on duty. However, rotas did not clearly show who was on duty and managers were not included on the rotas. On one occasion five staff were off sick and agency cover could not be provided. We noted that on 25 October 2013 the home advised us via E-mail that staffing levels were eight care staff which included two registered nurses for 22 people using the service. The current staffing complement of eight staff included one registered nurse to meet the needs of the 45 people currently using the service. A carer told us that at least 10 people had nursing needs, which was the same number as reported in October 2013. However, the number of nurses had been reduced by one.

We saw that the deployment of staff, on the day of the inspection, was three care staff on the ground floor (Willow Brook) to support nineteen people, four staff on the first floor (Cotton Meadow) to support twenty four people and one staff member on the second floor (Bluebell) to support two people. During our visit there was one person in Bluebell, they were being supported by one staff. The criteria for assessing who required nursing care and who required residential care was not clear. It was not clear why the people on the second floor of the home required higher staffing ratios than those living in the other areas.

One person told us: "my one complaint is that there are never, never enough carers". They described all the staff as "very kind and helpful' and said: "I can't praise the carers enough". However, she said that carers had no time to chat at all and sometimes she felt lonely as a result. Another person who had lived at the home for nearly a year and was unable to mobilise said it was: "hectic, I have to wait a long time for some things, like getting up for the toilet". They said: "the home doesn't seem to have enough staff to help".

One person described what happened when they were taken for a shower. They said: "they undress me and then say 'oh, I've just got to go and do something' and leave me. I sometimes get cold and put the towel around my shoulders". One person told us that there were: "plenty of staff, they don't take long to answer the bells and they always come if you need help".

At approximately 12.30 we noted that five of the 19 people who lived on the first floor were still in nightclothes. One person was still in bed at 2.30 pm. The person, still in bed, told us that they wanted to get up in the morning and their care plan noted that it was important to them to get up and dressed between 7.45 and 8.45. When staff were asked why the person had not been helped to get up they said: "no one has got her up". A carer told us later that there was not enough time to get everyone ready in the mornings. Relatives of someone who lived in the home told us that sometimes their family member was still in bed and unwashed at 11.00 or 11.30, when they visited. They said that on those occasions their uneaten breakfast things were still in the room. Others told us that they felt staff had too much to do but were: "always kind and considerate of their relatives needs". Some relatives told us they were concerned that their family members personal care needs were not met in a timely manner. We observed people calling out for a drink and assistance between 11.30 and 12.05. Staff did not respond to people's requests for help or assistance during the 35 minute time period. We heard people calling but did not hear any staff in the vicinity.

We noted that a call bell was sounding for 30 minutes before it was answered. A visiting professional told us that they had pressed the emergency bell and it had taken 20 minutes for a carer to arrive to help. Staff told us that there were enough staff if everybody 'turned up' but it was rare for people not to call in sick and they were always 'short'. Some staff felt people's safety and comfort was compromised on occasions. Rotas showed that there were numerous incidence of sickness.

The majority of staff we spoke with told us that they felt staffing levels sometimes put people at risk. They confirmed that it could take much longer than five minutes to answer the call bells. Other staff members told us that while they thought people were safe they did not receive the standard of care they should. They said that people frequently had to stay in bed because there were not enough staff to get them up. Staff and other professionals reported poor organisation and low staff morale.

Staffing shortfalls were covered by staff working extra hours or agency staff. However, staff often called in sick at very short notice and the agency was consequently unable to provide cover. The manager told us that any agency cover had to be sanctioned by a senior manager of the organisation. The regional operations manager told us that this did not cause any delays in obtaining agency staff. The manager told us that they were trying to recruit permanent staff. They confirmed that sickness was an issue in the home and it did leave staff shortages. The manager told us that they were trying to recruit more permanent staff and to the 'bank'.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Staff did not receive appropriate professional development. Some staff we spoke with told us that they had not received a comprehensive induction. They described their first week as: "being thrown in the deep end". They told us they did not feel confident that they had been properly prepared to offer safe care to the people who lived in the home. We were unable to review any induction records, on the day of the inspection as the management team were unable to locate them. They told us that they existed but we were unable to verify this.

We saw training records which showed that staff had completed training in core areas including safeguarding, moving and handling and end of life care. However, records showed that some care staff had either not started the mandatory courses or their training needed up-dating. An example was safeguarding vulnerable adults training which had not been started by 12 of the 58 staff.

Supervision records showed 51 care staff, of these 13 had not received any recorded supervision in 2014. The manager was unable to provide us with any supervision records which were not held in the staff files we reviewed. Care staff we spoke with confirmed that they did not receive regular supervision. Appraisal records were not available and staff told us they had not received appraisals.

The service held a staff meeting in July 2014 but meetings had not been held regularly prior to this. It was not clear when the last staff meeting had been held. Staff told us that there had not been a staff meeting for: "many, many months".

Staff were able, from time to time, to obtain further relevant qualifications. The manager told us that 23 of the 58 staff had been awarded the National Vocational Qualification (NVQ) 2 or above and seven staff were completing a qualification course.

Staff members told us that they did not have good opportunities for training and felt 'unsupported'. Some staff members told us they had no confidence in the new manager

and said: "I don't think she'll listen to us". The manager had been in post for eight days. Most staff did not feel they worked well as a team.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider had a system to regularly assess and monitor the quality of service that people receive. However, it was not effective as it had not identified shortfalls in important aspects of the care provided.

The provider had a system in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others. However it was not always effective as it had failed to identify that individual risk assessments were not always reviewed and up-dated.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found that the provider did not have a system to effectively assess and monitor the quality of service that people receive. The home had a quality assurance team based at head office and a senior manager completed a monthly quality monitoring visit. The last visit was recorded on 11 and 18 June when a temporary manager was in post. The home manager completed a variety of weekly, monthly and three monthly audits. Audit records were not readily available on the day of the inspection. The quality assurance system had not identified the shortfalls such as inaccurate care plans, incomplete daily recording and staff shortage and/or deployment issues.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted upon. The home held relatives and residents' meetings approximately every three months. The last meeting was held on the 29th May 2014. 13 people who used the service and four relatives attended. A quality of care questionnaire was sent every six months to people who used the service and other interested parties. These were sent back to head office who analysed them and sent a summary to the regional operations manager. The regional operations manager discussed the results with the manager and developed an action plan, as necessary. The manager gave us two examples of changes made as a result of listening to people who used the service. These were changing the menu and improving activities.

We saw that the provider had health and safety policies and procedures. The home had developed generic health and safety risk assessments along with risk assessments for individuals. However, risk assessments for individuals were not always reviewed or up-

dated in a timely manner. Examples of safe working practice risk assessments included expectant mothers and grass cutting/mowing. We saw that maintenance records were up to date. They included bedside electrical appliance testing, water quality and wheelchairs. The home had a generic evacuation plan and contingency response guidelines to tell staff how to respond in any likely emergency.

The provider took account of complaints and comments to improve the service. We saw that the provider had a comprehensive computer system to record and 'track' complaints. However, we were unable to see the content of the complaint and what investigation and action had been taken as a result of the complaint. The manager told us that it clearly showed on the system but did not provide us with this information. We were therefore unable to fully 'test' compliance in this area.

Most of the people we spoke with told us that they had never made any complaints but they would do so, if necessary.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person was not taking the appropriate steps to ensure each service user is protected against the risk of receiving care or treatment that is inappropriate or safe. Regulation 9. (1) (b)(i) and (ii).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: The registered person had not made suitable arrangements to ensure service users are safeguarded against the risk of abuse. Regulation 11. (1) (a), (2) (a) and (b).

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The registered manager was not protecting service users against the risk associated with the unsafe use and management of medicines. Regulation 13.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The provider had not taken appropriate steps to ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced staff employed for the purpose of carrying on the regulated activity. Regulation 22.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: The registered person did not have suitable arrangements in

This section is primarily information for the provider

procedures Treatment of disease, disorder or injury	place in order to ensure the persons employed for the purposes of carrying on the regulated activities are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. Regulation 13 (1) (a)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** **How the regulation was not being met:** The registered person did not protect service users and others who may be at risk, against the risk of inappropriate or unsafe care and treatment , by means of the effective operation of quality monitoring systems. Regulation 10.(1) (a)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 21 August 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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Wiltshire Council

Health Select Committee

23rd September 2014

Wiltshire Safeguarding Adults Board Annual Report 2013-14

Executive summary

The purpose of the report is to present the Annual Report of the Wiltshire Safeguarding Adults Board (WSAB) for consideration and comment by the Select Committee. The Annual Report reviews the work of the Board during 2013-14 and sets out the priorities for the current year; it includes contributions from all partner agencies. The attached report is in its final draft version, prior to sign off by the WSAB at its meeting on 22nd September. It will be presented to the Health and Wellbeing Board at its meeting in November.

Proposal

That the committee:

a) Notes and comments on the Annual Report.

b) Identifies any specific issues it wishes to be brought to the attention of the Health and Wellbeing Board when it receives the report.

Reason for proposal

The Council has a lead responsibility in relation to safeguarding adults who are defined as "vulnerable" or "at risk", which it discharges in partnership with other agencies. The Safeguarding Board brings together those agencies at senior level to ensure that the overall system is working in the interests of Wiltshire residents. It is therefore appropriate that the Select Committee has the opportunity to scrutinise the Board's work and make its views known.

Author: Margaret Sheather, Independent Chair of Wiltshire Safeguarding Adults Board

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Wiltshire Safeguarding Adults Board Annual Report 2013-14

Purpose of report

1. The purpose of the report is to present the Annual Report of the Wiltshire Safeguarding Adults Board (WSAB) for 2013-14 for consideration and comment by the Committee.

Background

2. 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.

3. Part of its responsibilities is to produce an Annual Report which reviews the past year's work and sets out priorities for the coming year. The final draft version of the report for 2013-14 is attached as Appendix 1 to this report.

Main considerations for the committee

4. The committee may particularly wish to note the following points.

    - The continuing impact of changes in public service structures and reductions in funding on the membership and work of the Board. This continues into the current year, with Healthwatch joining, and a change of representation from the Probation service in the light of their new structure.
    - The passing of the Care Act and the establishment of safeguarding adults work on a statutory footing.
    - The progress made during the year, responding both to national change and to local needs, summarised in the Foreword. The establishment of a Service User Reference Group is one of the highlights of this year's work
    - The overall developments and achievements of the Board described in section 3 and those of the partner agencies in section 6.
    - The Serious Case Review outlined in Section 4
    - The continued increase in the volume of safeguarding work identified in section 5 and the associated data in the Appendix
    - The priorities for the current year and beyond, that are set out in section 8.
    - The full Business Plan at Appendix 5.

Environmental impact of the proposal

5. There are no environmental impacts from this report.

Equality and diversity impact of the proposal

6. The work of the WSAB has a significant role to play in promoting equality. It contributes to ensuring that all Wiltshire residents, whatever their circumstances or needs for support, can live free from the fear of harm or abuse, that they are treated with dignity and their choices respected.

Risk assessment

7. There are no specific risks associated to the proposed actions in this report. However, the assessment and management of risk generally is central to effective safeguarding work, both with individuals who are at risk and in the management of safeguarding in individual organisations and by the WSAB. The Board continues to use its risk register to ensure that it tracks the risks to the overall safeguarding arrangements that may arise from the local and national developments.

Financial implications

8. There are no financial implications arising directly from this report. The WSAB does not currently have an identified budget, and discussions have started about how to establish this on a partnership basis.

Legal implications

9. There are no legal implications arising directly from this report.

Background papers

The following unpublished documents have been relied on in the preparation of this report: None.

Appendices

Appendix 1 – Wiltshire Safeguarding Adults Board Annual Report 2013-14.

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Wiltshire Safeguarding Adults Board

Annual Report

2013 – 2014

Contents

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 Service 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.
- 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

[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 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)

[4] Policy and Crime Commissioner

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.

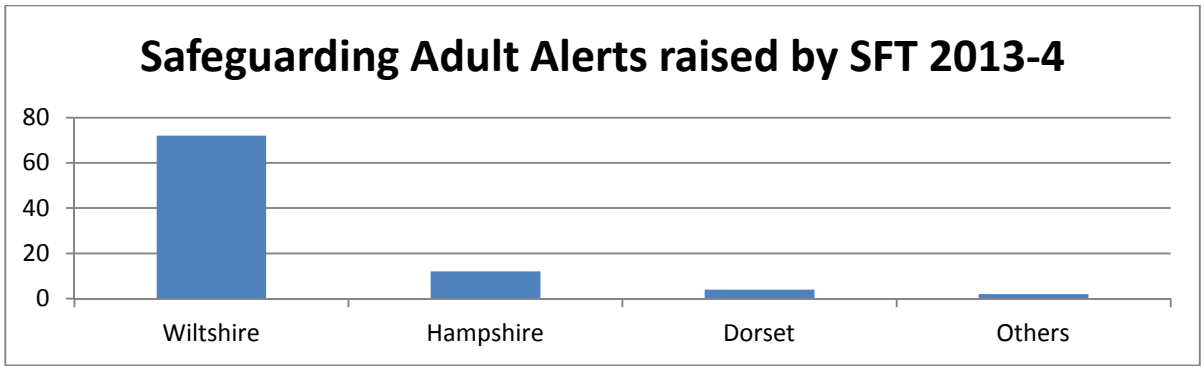
Gill Cobham is the Safeguarding Adults at Risk/ MCA Lead Nurse and is a member of the Policy & Procedures Sub-Group. The Safeguarding Adults at Risk Lead Nurse has responsibility for supporting staff using the Safeguarding Policies & Procedures, increasing awareness of Safeguarding Adults within the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

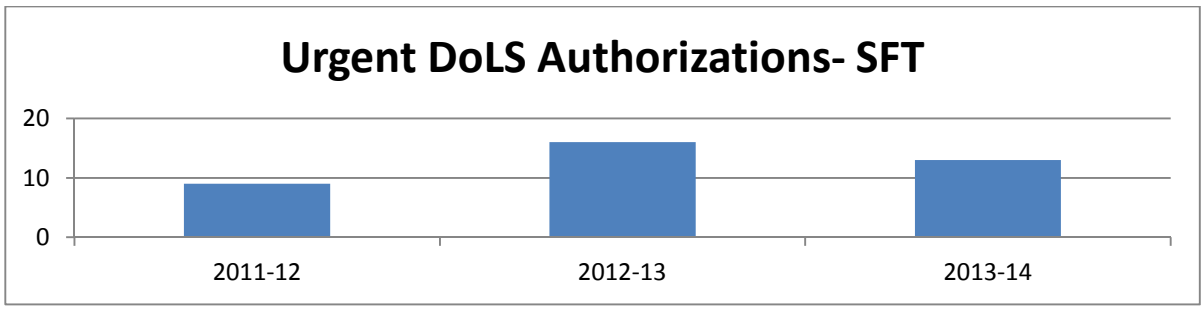
Achievements in 2013-14

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.

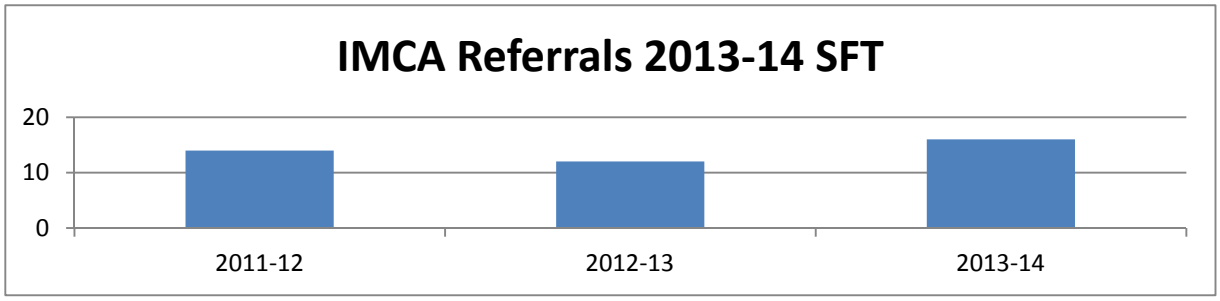
Awareness of Safeguarding continues to increase across the organization. In 2013-14 90 alerts were raised with Local Authorities, a 32% increase on 2012-13.



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

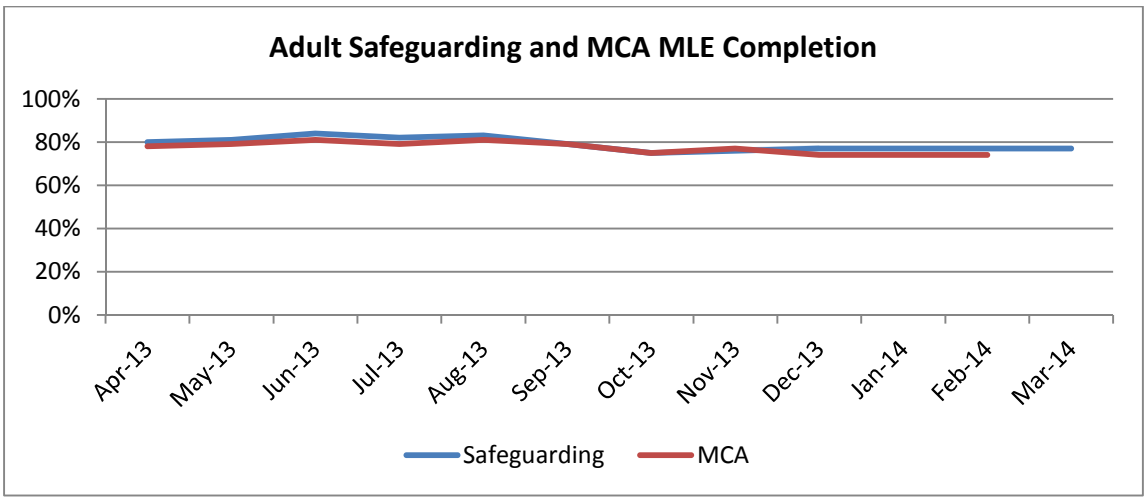


IMCA referrals increased by 25% in 2013-14



- 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
- 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.

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	• Safeguarding Manager

NHS Foundation Trust	
Wiltshire Fire & Rescue Service	• Station Commander
National Probation Service	• Assistant Chief Officer
Community Rehabilitation Company	• Assistant Chief Officer
Healthwatch Wiltshire	• 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

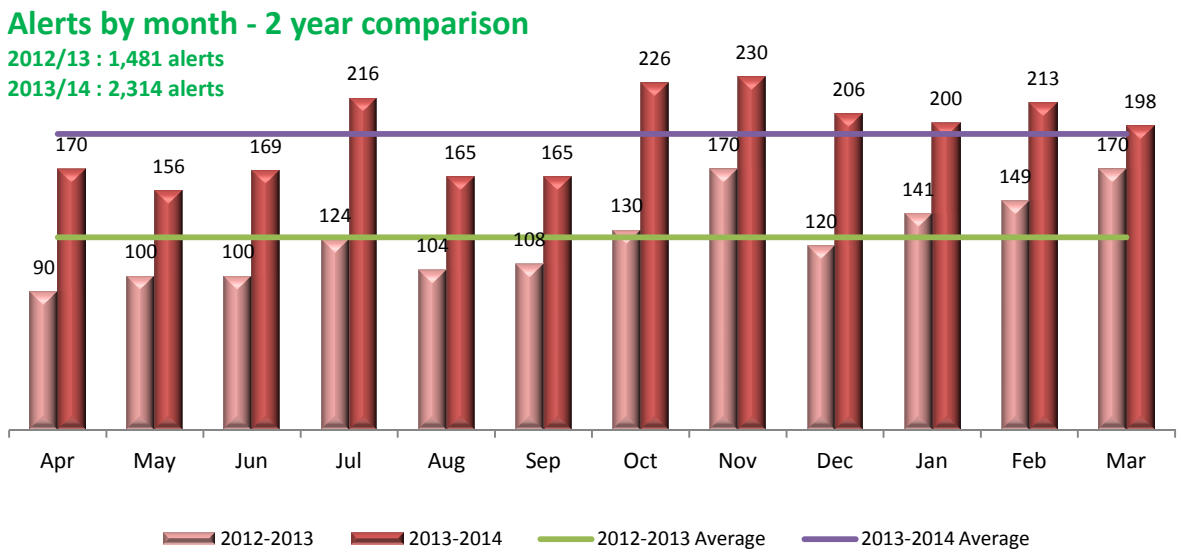
Previous year totals and comparative data, current year-to-date

	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										

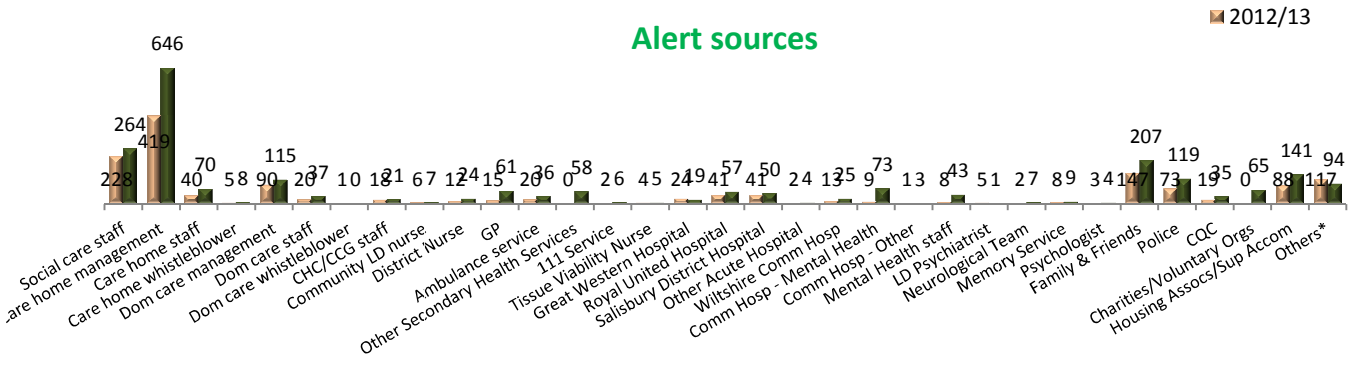
ABUSE ALERTS



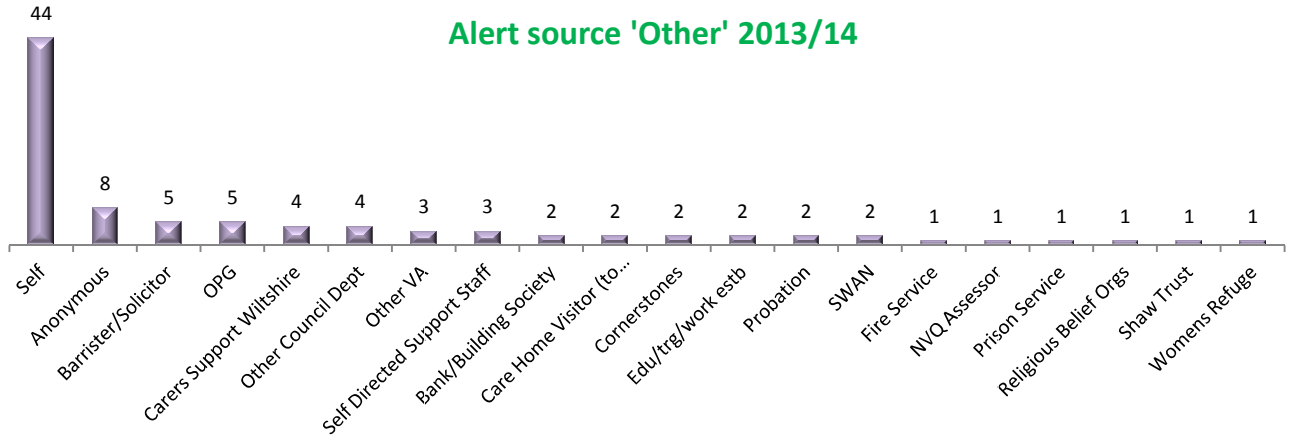
The number of Alerts has continued to increase, from an average of 126 per month in 2012/13 to 193 in 2013/14. It is thought that this arises from a combination of improved recording since the formation of SAMCAT, greater reporting of individual cases by care agencies and a greater awareness of safeguarding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

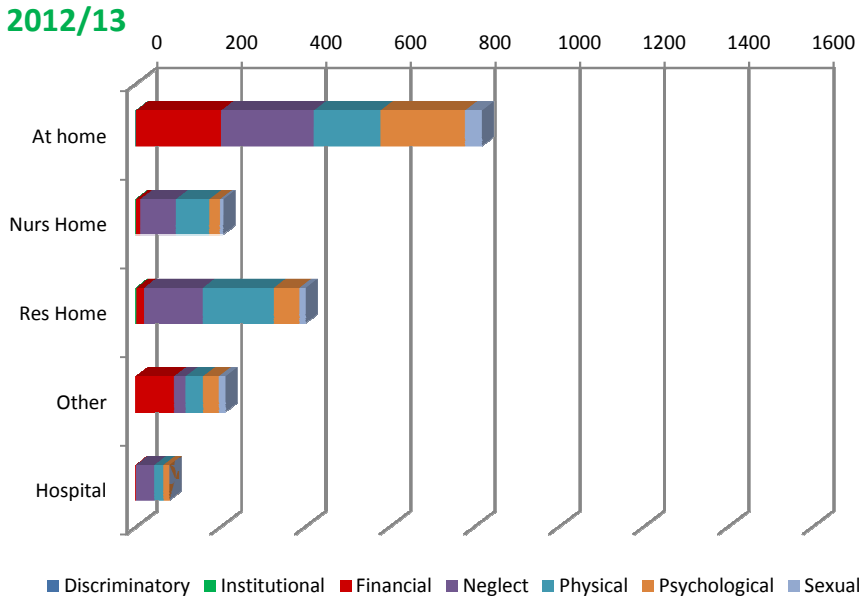
Broadly, the patterns of the type of abuse in the various settings are similar across both years. There are very few reported cases of discrimination (1 in 2012/13 and 2 in 2013/14), but it may surprise that these occurred in people's own homes rather than in care home settings, but this category includes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

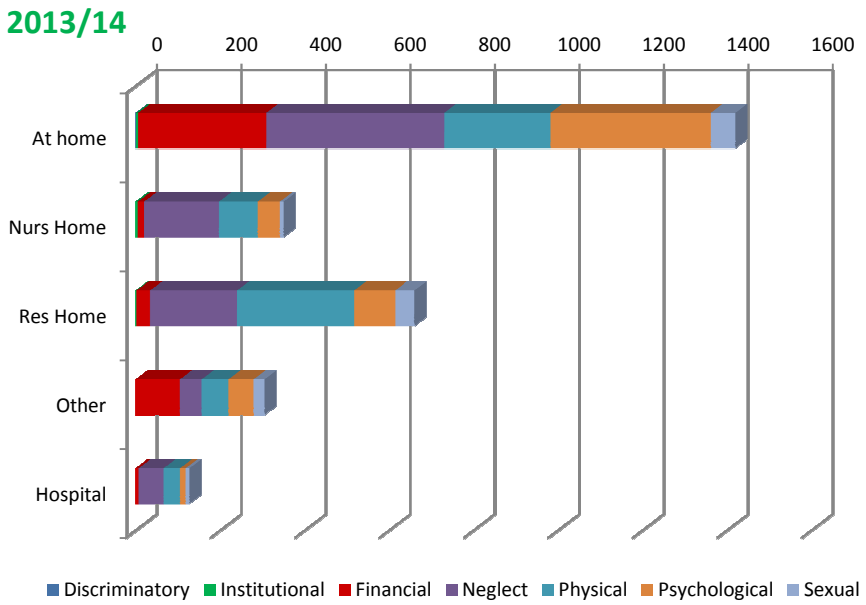
The majority of neglect or acts of omission occur in own home situations (43% of neglect cases in 2012/13 and 46% in 2013/14) sometimes related to the impact of pressure on informal carers. Care homes saw 44% of such cases in 2012/13 and 42% in 2013/14. These tend to be missed medication, not supporting 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.

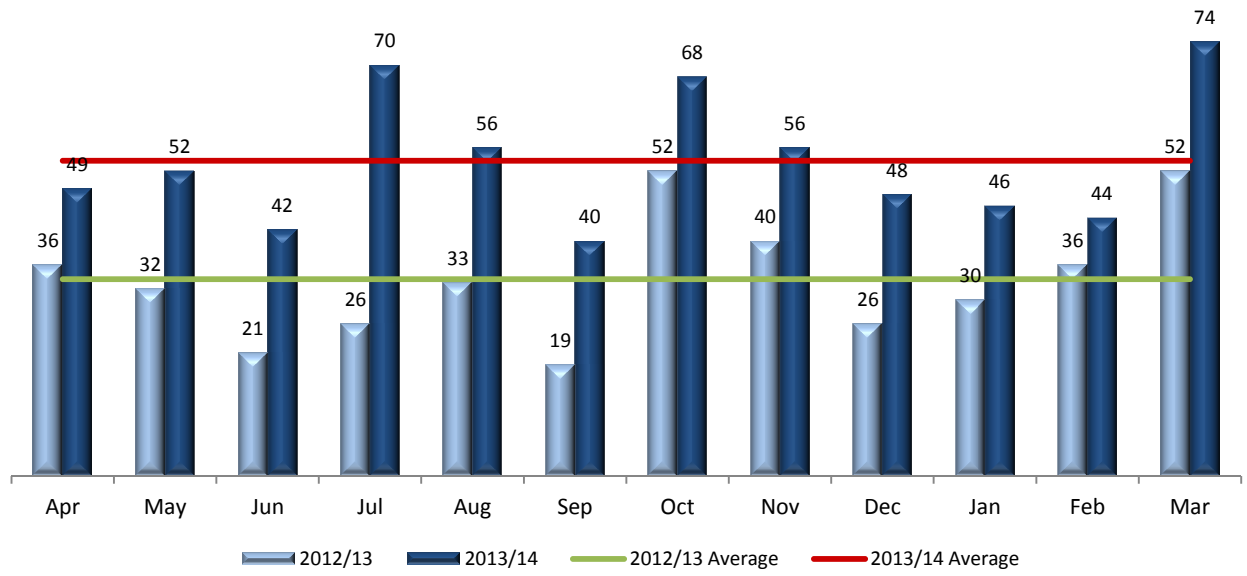




ADULT PROTECTION INVESTIGATIONS

Investigations started during the reporting period

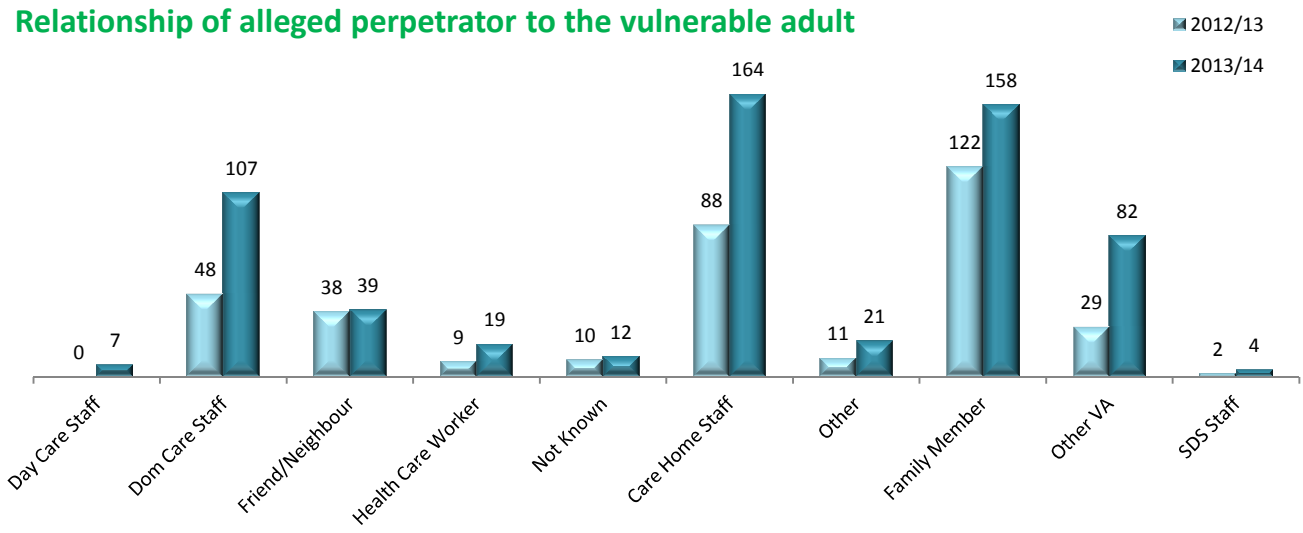
30% of alerts went on to be investigated in 2013/14, similar to 2012/13 (29%). Overall, the number of Adult Protection Investigations (APIs) has risen proportionately with the increased number of Alerts received with 645 APIs started in 2013/14 compared with 403 in 2012/13.



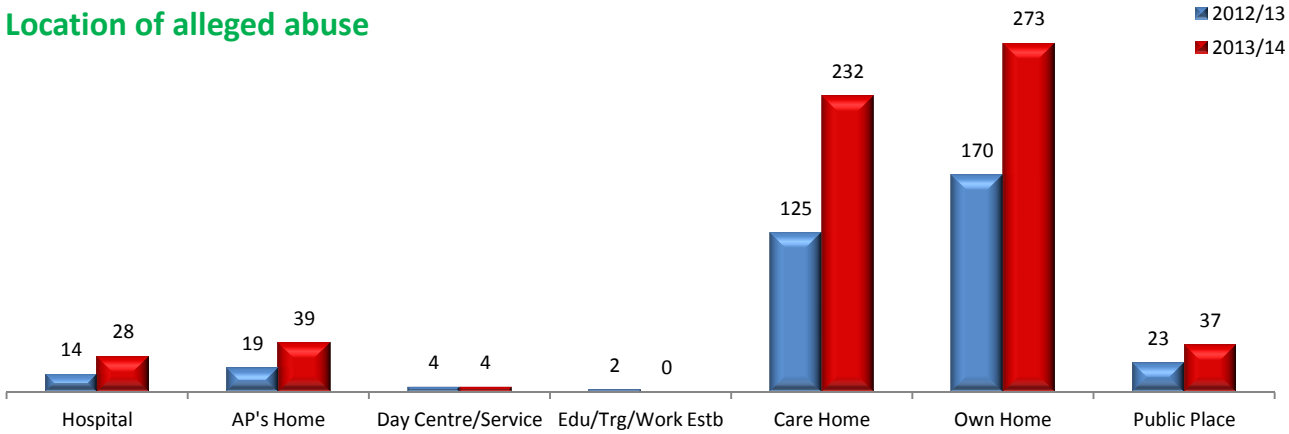
Relationship of the alleged perpetrator to the vulnerable adult

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.



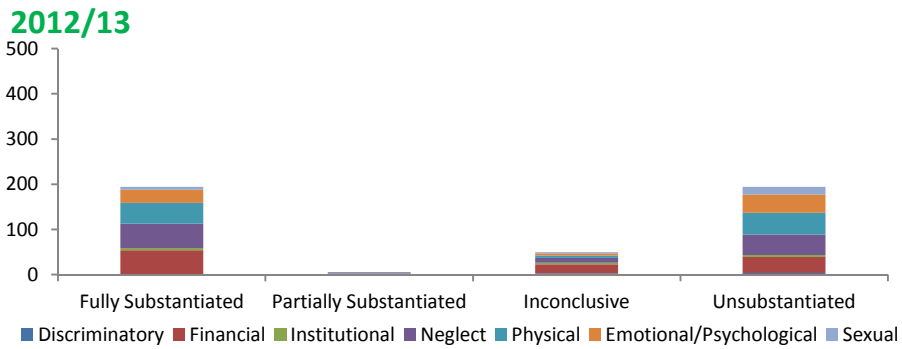
Location of the alleged abuse

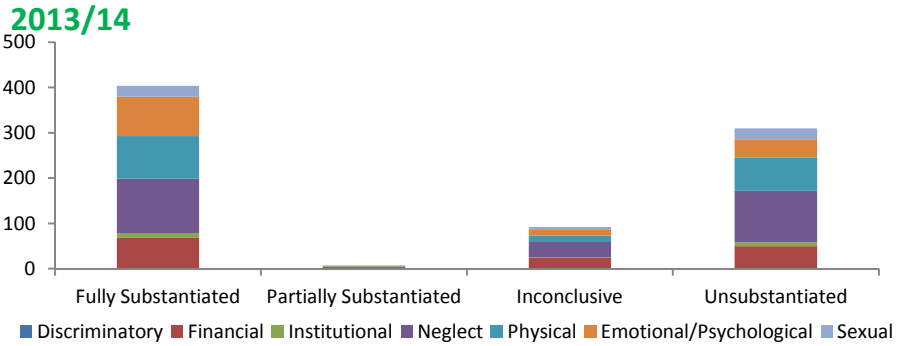


Care home and the vulnerable adults' own home dominate the locations where abuse is alleged to have taken place, with own home averaging 46% across the 2 years covered by this report and care homes averaging 36%. This reflects the relationships of the vulnerable adults to the Alleged Perpetrators above.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





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:

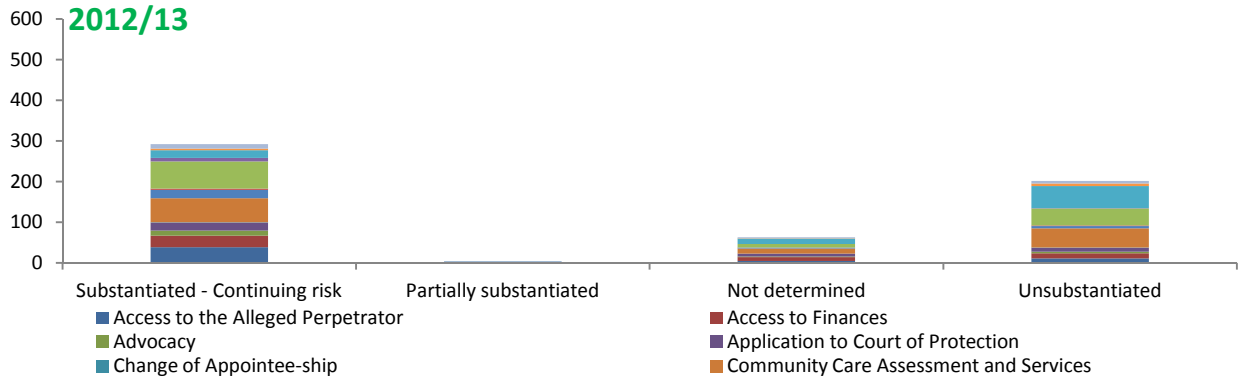
	Fully Substantiated	Partially Substantiated	Inconclusive	Unsubstantiated
	(numbers in brackets are total number for each conclusion)			
2012-2013	44% (194)	1% (5)	11% (50)	44% (194)
2013-2014	50% (404)	1% (7)	11% (92)	38% (310)

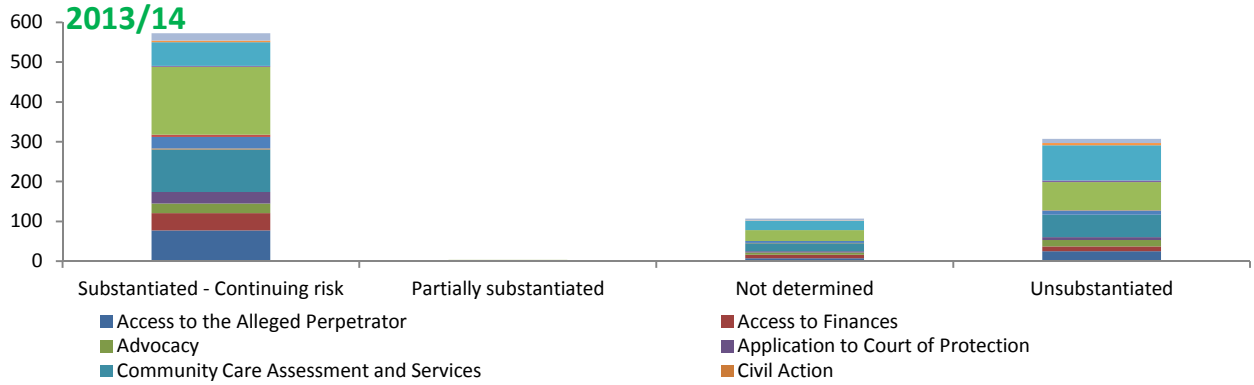
*8*Note that in 2013/14, 5 investigations ceased at the VA's request*

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:

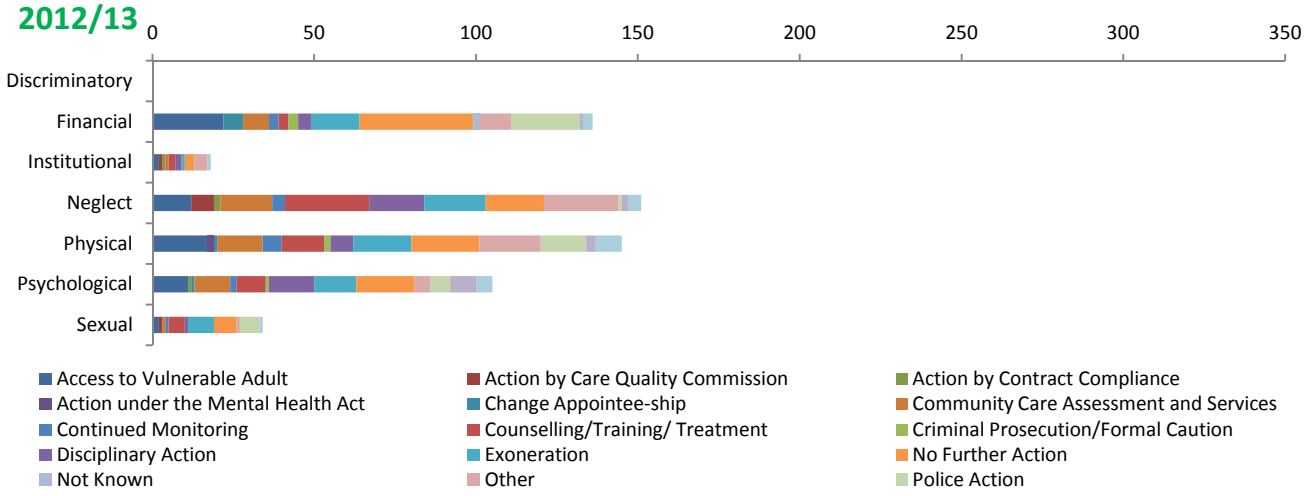




Outcomes for the alleged perpetrators

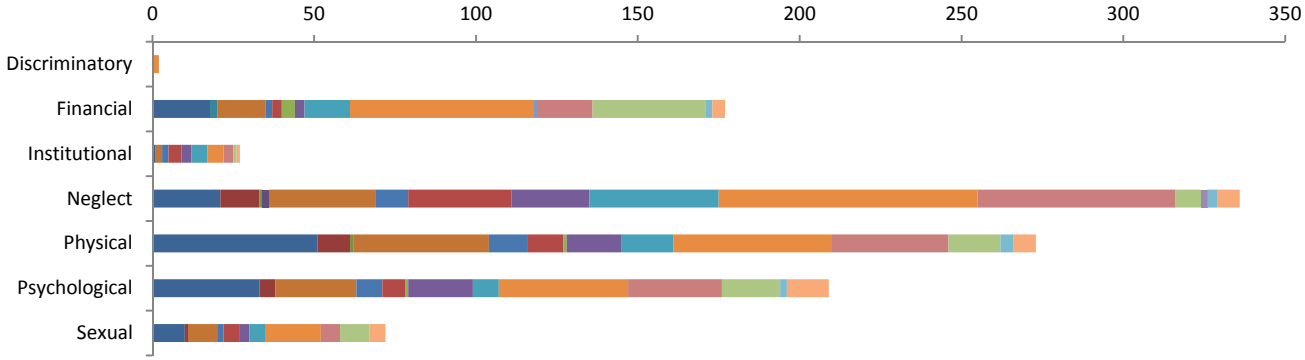
With the well-being of the victim upper most, outcomes for the alleged perpetrators will focus on removing or reducing risks to vulnerable adults and so individual cases will dictate alleged perpetrators' outcomes. These charts depict the outcome for the alleged perpetrator(s) and show the types of abuse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

2012/13



- Access to Vulnerable Adult
- Action by Care Quality Commission
- Action by Contract Compliance
- Action under the Mental Health Act
- Change Appointee-ship
- Community Care Assessment and Services
- Continued Monitoring
- Counselling/Training/ Treatment
- Criminal Prosecution/Formal Caution
- Disciplinary Action
- Exoneration
- No Further Action
- Not Known
- Other
- Police Action

2013/14



- Access to Vulnerable Adult
- Action by Care Quality Commission
- Action by Contract Compliance
- Action under the Mental Health Act
- Change Appointee-ship
- Community Care Assessment and Services
- Continued Monitoring
- Counselling/Training/ Treatment
- Criminal Prosecution/Formal Caution (Crim Action)
- Disciplinary Action
- Exoneration
- No Further Action
- Not Known
- Other
- Police Action
- Referral to Registration Body
- Referred to POVA List/ISA
- Removal from Property or Service

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 Management systems are effective and include indication of the potential for vulnerability and intervention	Finalise and implement the Board's performance and QA 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 policy and procedures consistently.	TBA	Task group as above. MS /KE
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**	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	Quarterly September '14 September '14	Chair WSAB meetings/ members

occur	Healthwatch and housing providers. e) Ensure continued commitment from partners to the Board and its sub-groups ii) Consider and respond to specific guidance/ reports including • SCIE report on Safeguarding in housing • Mental Health Crisis Care concordat • Positive and Safe programme	Ongoing Ongoing TBC	All Chair 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	September '14	Chairs of Wiltshire and Swindon boards Policy and procedures sub-group P & P sub-group/

	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) Monitor development of proposals for establishing a Multi-agency Safeguarding Hub (MASH) for adults	 March ’15 December ’15	MA and others WSAB Phil Shire/James Cawley 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.	September ’14 September ’14 Autumn December ’14	Chair Phil Shire/ James Cawley Chair Board members

	f) Consider Memorandum of Understanding between WSAB and Wiltshire Care Partnership, once MoU with Wiltshire Council has been established.	Each meeting TBC	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 adults at risk and their carers are aware of their safeguarding responsibilities	Distribute new awareness raising materials to all relevant organisations and follow up their use of them.	When available.	Communications task group/ 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**
3.1 There is a comprehensive accessible public information and	i) Agree actions from the report of the Communications and Publicity Task Group including:		

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**
advice about keeping safe and what constitutes abuse of adults at risk	a) Overall Communications Strategy b) Proposals for improved publications c) Proposals for website development ii) Review implementation iii) Agree arrangements for maintaining good quality information.	June ’14 December ’14 December ’14 Implementation + 6 months March ‘15	WSAB WSAB WSAB WSAB WSAB
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	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.	Ongoing December ’14	MS / WSUN MS / CM/ Carers Wiltshire

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**
delivery of safe services	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	March '15	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 Assurance arrangements	a) Commit to the next stage of the Making Safeguarding Personal project. b) Through this and other means ensure that service user outcomes are routinely identified, monitored and reported.	September '14 6 monthly	Wiltshire Council 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 how it contributes to safeguarding adults.	June ’14 November ‘14 October ‘14 See 1.1	WSAB
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	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 Blick/PS MS

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**
Capacity Act (MCA) 2005			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		
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	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 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**
Hospital			
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 have been appropriately trained according to their role	Implement SAB Strategy for Competence Development a) Confirm arrangements to monitor training both at Board and individual organisation level 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.	September '14 Ongoing TBA	L & D sub-group Chair 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**
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 Care Act 2014, including a stakeholder conference	Ongoing Ongoing Ongoing December '14	L & D sub-group L & D sub-group L & D sub-group L & D sub-group
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.		

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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

Wiltshire Council

Health Select Committee

23rd September 2014

Subject: **Wiltshire Mental Health and Wellbeing Strategy – Draft for information prior to consultation**

Executive Summary

The purpose of this item is to present an update on the progress of the Wiltshire mental health strategy and the plans for its consultation process.

The draft Wiltshire Mental Health and Wellbeing Strategy (see Appendix 1) provides the strategic direction for Wiltshire Council and NHS Wiltshire Clinical Commissioning Group (CCG) in promoting mental health and wellbeing and supporting people with mental health problems and their carers over the next 7 years.

The aim of the strategy is to create environments and communities that will keep people well across their lifetime, achieving and sustaining good mental health and wellbeing for all.

Following the development of the draft strategy, the draft has been presented for approval to the Wiltshire Clinical Commissioning Board and to Wiltshire Council Cabinet for approval of the draft content and to progress to consultation. It is being presented to Health Select Committee for information and feedback.

Proposal(s)

To provide information for Health Select Committee on the draft Strategy and consultation.

Frances Chinemana
Associate Director Public Health and Public Protection

Purpose of Report

1. This report provides information for the Health Select Committee on the draft Mental Health and Wellbeing Strategy and consultation.

Background

2. The draft Wiltshire Mental Health and Wellbeing Strategy (see Appendix 1) provides the strategic direction for Wiltshire Council and NHS Wiltshire Clinical Commissioning Group (CCG) in promoting mental health and wellbeing and supporting people with mental health problems and their carers over the next seven years.

3. The aim of the strategy is to create environments and communities that will keep people well across their lifetime, achieving and sustaining good mental health and wellbeing for all. It is a high level vision document designed to enable development of commissioning and delivery plans address the key areas for development and which contribute to achievement of this overall aim.

4. In developing the strategy, stakeholder engagement has been undertaken with a wide variety of local professionals and partners who work within the field mental health, and with our service users via the Wiltshire Service User Network (WSUN). Key messages from the stakeholder and service user engagement are included in the draft strategy. In addition to we have taken into account key messages from international and national organisations such as the World Health Organisation, Department of Health, Royal Colleges, national reports including those from national mental health charities and our own strategic direction over the next five years. Evidence from the Joint Strategic Assessment has been used to underpin the strategy and highlight particular areas of focus.

5. In addition we have taken into account key messages from international and national organisations such as the World Health Organisation, Department of Health, Royal Colleges, national reports including those from national mental health charities and our own strategic direction over the next five years.

Proposed consultation process

6. Following the development of the draft strategy, it has been presented to the Wiltshire Clinical Commissioning Board and to Wiltshire Council Cabinet panel for approval of the draft content and to progress to consultation. It is being presented to Health Select Committee for information and feedback.

7. It is intended that a consultation period will subsequently run from October 2014 until January 2015. This will consist of Wiltshire Council and Wiltshire Clinical Commissioning Group, who led the development of the strategy, issuing an invitation to the general public and interested

stakeholders to participate and provide feedback on the draft document. During this period, further engagement events will take place with stakeholders and users via WSUN and other established forum.

8. Once the responses to the consultation have been analysed, a final strategy will be produced and presented for formal approval. Commissioning and delivery plans will then be developed to deliver the agreed strategy.

Safeguarding Implications

9. Safeguarding is a key priority for Wiltshire Council and NHS Wiltshire CCG, both in terms of the services that they deliver and commission and this applies equally to the Wiltshire Mental Health Strategy and its implementation. It is acknowledged that people with mental health difficulties can be at greater risk of being victims of crime or abuse, self-neglect and poor and undignified care, given that they often lack capacity and their situations can give rise to increased risk of exploitation, e.g. financial, and stress within care givers, if they are not in receipt of appropriate support and training.

10. Wiltshire Council and NHS Wiltshire CCG and the organisations that they commission have in place safeguarding policies, procedures and workforce development plans to ensure that safeguarding is and continues to be a key priority.

Public Health Implications

11. The proposed public consultation on the Wiltshire Mental Health and Wellbeing Strategy helps to ensure that the population continues to be included in decision-making processes regarding their health and wellbeing.

12. Poor mental health can have a devastating impact on the quality of life for individuals their families and carers as well as a significant impact on the national economy. It has links to poverty and exclusion, unemployment, crime, chronic illness and anti-social behaviour. People with a mental health issue are more likely to die prematurely and to develop physical health issues. The national strategy for mental health, No Health without Mental Health: A cross-government mental health outcomes strategy for people of all ages (DH 2011), shows why tackling mental illness and promoting mental wellbeing is essential not only for individuals and their families but to society as a whole. Public Health staff will continue to work closely with Adult Social Care and NHS staff to develop and deliver this strategy, with a number of healthy living schemes already in place to assist in reducing the risk of developing mental health issues.

13. The outcomes of this strategy should help to reduce health inequalities and improve healthy life expectancy for the whole population of Wiltshire as well as people with mental health issues and their carers, and also may help to reduce the future prevalence. The Wiltshire Mental Health and

Wellbeing Strategy is thus consistent and coherent with the aims of the Wiltshire Health and Well Being Strategy.

Environmental and Climate Change Considerations

14. There are no environmental or climate implications in relation to this cabinet paper.

Equalities Impact of the Proposal

15. The strategy aims to ensure services will be delivered with due regard to equality legislation and that people with mental illness will have equitable access to services according to need. An equality analysis will be undertaken during the consultation period and will be presented alongside the final strategy.

Risk Assessment

Main risks associated with the proposed consultation on the Mental Health and Wellbeing Strategy:

16. Raised expectations of what the mental health and wellbeing strategy will deliver amongst the general public, customers and partner organisations as a result of the strategy development and consultation. This will be managed through ensuring that priorities identified from the early engagement and the consultation, are balanced within the overall resources available to deliver the strategy. This will be communicated within the final strategy and through a continuing programme of engagement with the general public, customers and partner organisations which will allow for priorities and progress to be communicated.

Risks that may arise if the proposed decision and related work is not taken

17. Resulting delay in commencement of the consultation period would lead to an extended period without a current Mental Health and Wellbeing Strategy in place and lack of clarity over mental health and wellbeing priorities to inform commissioning and delivery.

Financial Implications

18. There are no immediate financial implications of the proposal to launch a consultation on the Mental Health and Wellbeing Strategy. It is however, acknowledged that the key areas for development identified within the strategy may require some re-alignment of budget, particularly over the longer-term, to enable better cross-agency working.

Legal Implications

19. No direct legal implications have been identified in relation to the proposal save for mental health being a protected factor under the Equality Act 2010.

Frances Chinemana
Associate Director Public Health and Public Protection

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15th September 2014

Background Papers

The following unpublished documents have been relied on in the preparation of this report:

None

Appendices

Appendix 1: Draft Mental Health and Wellbeing Strategy 2014 to 2021

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Wiltshire Mental Health and Wellbeing Draft Strategy

NHS Wiltshire Clinical Commissioning Group

Wiltshire Council
Where everybody matters

2014 - 2021

Welcome

Welcome to the Wiltshire Mental Health Draft Strategy 2014 - 2021 (draft). Here we set out our ambition over the next three years to improve the mental health and emotional wellbeing of Wiltshire residents and meet the aims of the national mental health strategy.

We are already rising to the challenge of improving mental health and wellbeing and have achieved some key successes in recent years - but we know we need to go further to achieve our ambitions and improve outcomes.

Mental health is **'everybody's business'.** Change on this scale cannot be delivered by organisations working alone. We are committed to working together with individuals, families, employers, educators, communities and the public, private and voluntary sectors to promote better mental health and to drive transformation.

Maggie Rae
Corporate Director,
Wiltshire Council

Keith Humphries
Cabinet Member,
Public Health,
Protection Services,
Adult Care and
Housing

Sheila Parker
Portfolio Holder,
Learning
Disability and
Mental Health

Deborah Fielding
Chief Accountable
Officer
Wiltshire CCG

Celia Grummitt
GP Mental
Health Leads

Debbie Beale
GP Mental
Health Leads

Introduction

Our aim for Wiltshire is to create environments and communities that will keep people well across their lifetime.

Acknowledgements:
This strategy is led by Frances Chinemana, Associate Director for Public Health and Public Protection and thanks is extended to all those involved in the development of the draft including: Alex Thompson-Moore, Victoria Hamilton, Mike Naji, Dugald Millar, Annie Paddock, Karen Spence, Wiltshire and Swindon Users Network and all the service users and professionals who shared their views and experiences.

Awaiting photo

Richard Hook
GP Mental Health Leads

This seven year joint strategy sets out our strategic priorities for adult mental health and wellbeing provision in Wiltshire and our focus for delivering services, facilities and opportunities that empower people and enable independence. The strategy has been developed in consultation with key stakeholders and is in line with the national strategy "No Health without Mental Health" and with the Wiltshire Health and Wellbeing Strategy.

Our aim for Wiltshire is to create environments and communities that will keep people well across their lifetime, achieving and sustaining good mental health and wellbeing for all. We will do this through six areas of activity:

1. Prevention and early intervention (including mental wellbeing for expectant and new mothers)
2. Promoting emotional wellbeing and tackling stigma and discrimination
3. Personalised recovery based services with a wellbeing perspective
4. Effective and efficient use of resources to ensure value for money
5. Closer collaboration with service users, families and carers in the development of services
6. Joint working with a wider group of statutory services

Poor mental health can have a devastating impact on the quality of life for individuals their families and carers as well as a significant impact on the national economy. It has links to poverty and exclusion, unemployment, crime, chronic illness and anti social behaviour. People with a mental health issue are more likely to die prematurely and to develop physical health issues.

This strategy is primarily concerned with tackling mental ill health and promoting wellbeing in adults. Separate strategies exist or are being developed that are interdependent with the mental health strategy including the Dementia Strategy and the Children and Young People's Emotional Health and Wellbeing Strategy. These and other strategies have been considered during the development of the Mental Health Strategy to ensure consistency. It will be essential to ensure that these links are further explored during the development of commissioning and delivery plans for the strategy in order to maintain the focus on good mental health and wellbeing across the whole life cycle and a whole person approach. Of particular importance is the approach to transitionary care to ensure that our systems enable the individual to continue to have the best possible outcomes regardless of the stage they are at in their life cycle.

Developing the Strategy

'Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential'.

Outcomes - How will the strategy improve things for people?

Mental health is everyone's business, the national mental health strategy states, 'good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential'. There has been a fundamental change to the way public services are structured, and commissioned with an ethos to deliver identified outcomes which address the needs of the local population. Our local outcomes are underpinned by the National mental health strategy objectives which are:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination.

We will measure how successful our strategy is by developing measures and information that will help us to understand whether we are achieving these outcomes for people in Wiltshire.

Who Contributed to this Strategy?

In addition to ensuring we have taken into account key messages from international and national organisations such as the World Health Organisation, Department of Health, Royal Colleges, national reports including those from national mental health charities and our own strategic direction over the next five years, stakeholder engagement has taken place with a wide variety of local professionals and partners who work within the field mental health, and with our service users via the Wiltshire Service User Network (WSUN).

Key messages for the strategy from service users were:

- Essential to put the needs of the person first. Services should be person centred and wholly inclusive. The service user should be thought of in terms of the whole person and not just medically.
- There needs to be a greater effort to promote self-esteem and sense of worth. People need to be made aware that they can live well with mental health issues.
- Professionals, more particularly health and council services, should really embrace the third sector, understand the value of the work they do and recognise their worth.
- It is necessary to understand that different things work for different people at different times.
- Listen to the service users' they are the experts of experience. Treat them as you would wish to be treated.
- Improve community knowledge for professionals.

Key messages for the strategy from professionals were:

- Early access, not a threshold that one has to reach a crisis and ease of access countywide
- Continuity across the system and a holistic approach to include things like housing, employment, finances, wide ranging interventions e.g. wildlife, LIFT, art, pets, farm
- Crisis does not occur only in office hours, people should be able to access the information or assistance they need regardless of when it is needed
- Better joining up – intra-service, across services, across ages.
- Gaps in service provision e.g. PTSD, autism, dual diagnosis, alcohol and drugs, veterans, personality disorder, parenting
- Community education and reducing the stigma. Prevention, promotion and the community including primary care, improving social capital

- Community care where appropriate
- Improved, accessible signposting of services available/where to go for help
- Service user centred, service user choice, service user involvement
- Develop peer support and carer support
- Accommodation
- Transport
- Use of IT effectively

Why is Mental Health and Wellbeing a Priority?

What do we mean by mental health and wellbeing?

It is where you have a sense of happiness and wellbeing arising from self empowerment, security, good relationships and healthy lifestyle choices.

The World Health Organisation defines mental health as:

"a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."

Needs Assessment Summary

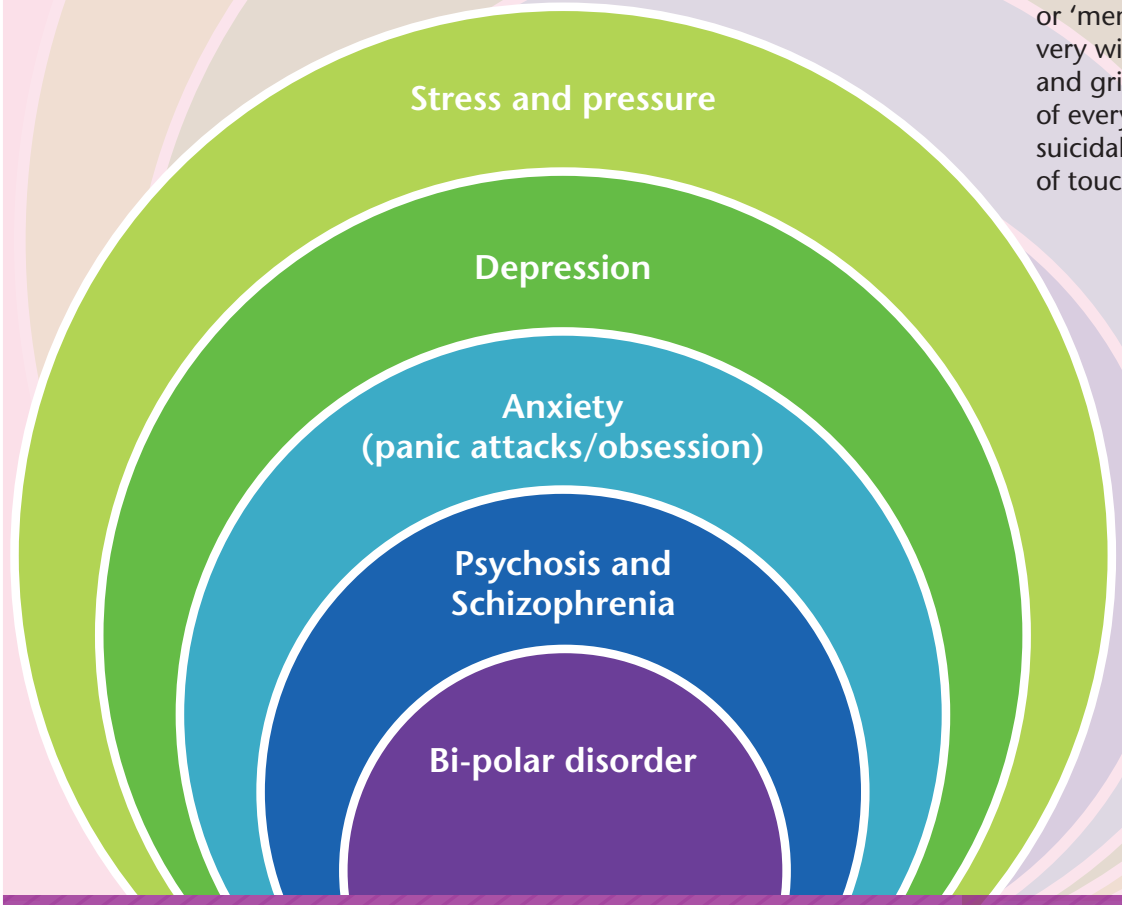
The national strategy for mental health, No Health without Mental Health: A cross-government mental health outcomes strategy for people of all ages (DH 2011), shows why tackling mental illness and promoting mental wellbeing is essential not only for individuals and their families but to society as a whole:

- At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time.
- Almost half of all adults will experience at least one episode of depression during their lifetime.
- One in ten new mothers experiences postnatal depression.

- Mental ill health represents up to 23% of ill health in the UK and is the largest single cause of disability.
- People with severe mental illnesses die on average 20 years earlier than the general population
- The NHS spends around 11% of its budget on Mental Health, almost double that spent on cancer.

Mental ill-health

The definition of 'mental ill health' or 'mental health problems' covers a very wide spectrum, from the worries and grief we all experience as part of everyday life to the most bleak, suicidal depression or complete loss of touch with everyday reality.



The Local Picture - Level of need in Wiltshire

The Wiltshire Joint Strategic Assessment (JSA) provides information on the current and future health and wellbeing needs of people in Wiltshire. The current JSNA can be found here:
www.intelligencenetwork.org.uk/joint-strategic-assessment

In addition to the JSA there is also a Joint Strategic Assessment for Health and Wellbeing. The assessment for 2012/13 provides a summary of the current and future health and wellbeing needs of people in Wiltshire. Section 5 of the JSA for Health and Wellbeing focuses on the burden of ill health in relation to mental health and neurological disorders. It estimates that (based on the study Adult Psychiatric Morbidity in England 2007) approximately 60,000 adults in Wiltshire have a common mental disorder (CMD).

Some specific areas for consideration are additionally highlighted:

- Serious mental illness; psychosis and affective psychosis: Psychoses can be serious and debilitating conditions, associated with high rates of suicide. The Quality Outcome Framework 2010/11 mental health register which includes people with schizophrenia, bipolar affective disorder and other psychoses included 3,090 people in Wiltshire (0.7% of registered population).
- Suicide rates in the South West rose by 24% between 2007 and 2009. In England overall there was a rise of 10% over the same period. Between 2006 and 2009, there were 205 deaths in Wiltshire that were given a verdict of suicide or injury undetermined.
- Between 2002 and 2009 the South West saw a rise of 73% admission for self-harm, particularly in women aged 15-24, against a national rise of 49% over the same period. Wiltshire has a statistically significantly higher directly standardised rate for emergency hospital admissions for self-harm compared to England. 'Self-harm' includes a range of behaviours including self-cutting and poisoning. Self-harm is often thought to be a way of managing distress and involves differing degrees of risk to life and suicidal intent.

Further information about mental health diagnoses, at risk groups and Wiltshire statistics can be found in the Wiltshire JSA for Health and Wellbeing, Section 4: burden of ill-health: mental health and neurological disorders.

The Wiltshire Health and Wellbeing Board Strategy 2014-15 highlights the importance of access to emotional support and to mental health awareness training within two of its key theme's on Prevention and Independence. The Wiltshire Council Business Plan and the CCG 5 Year plan also reflect the importance of mental wellbeing in delivering better overall health and resilience within communities and among individuals.

Further information about mental health diagnoses, at risk groups and Wiltshire statistics can be found in the Wiltshire JSA for Health and Wellbeing, Section 4: burden of ill-health: mental health and neurological disorders.

How we will work together

Joint Commissioning

To realise its vision of stronger communities in which everyone is able to achieve their potential Wiltshire Council and the Clinical Commissioning Group are committed to joint commissioning for mental health. This will build on existing arrangements which will enable a co-ordinated, efficient and therefore responsive and cost-effective service that allows for enhancing quality of life for all.

In line with our Joint Health and Wellbeing Strategy 2014-2015, and Wiltshire CCG's Five Year Plan 2014-2019, we seek to design and deliver mental health and wellbeing in the county to improve the service user experience and ensure that people can be confident that:

- I will be supported to live healthily
- I will be listened to and involved
- I will be supported to live independently
- I will be kept safe from avoidable harm.

For those with long-term enduring health issues we will work to enable the recovery journey and optimise independence and quality of life.

A concept has been developed for a future health and care Model for mental health which is in line with the CCG overall model for health and care as represented in their 5 year plan. This model identifies the different layers and levels of care and support required to manage ill health and establish and sustain wellness and independence; pictorial representation of this can be seen at Appendix 1.

Tackling unhealthy lifestyles, helping those at risk from ill health and dealing with the increase in illnesses associated with living longer is something public services, other agencies and communities need to do together. The model we propose for mental health and wellbeing is community based (in line with our approach across all health and wellbeing) and will focus on:

- strengthening social capital with our local partners and organisations, optimising the opportunities offered by community campuses, area boards and other community resources such as voluntary and support groups
- enhanced seven day primary care and community based solutions with improved multidisciplinary services wrapped around general practice reducing reliance on acute care
- a simple point of access for health and social care and for these multidisciplinary teams to share data and information with increasing use of shared technology to avoid duplication in assessments
- encouraging personal responsibility
- addressing the wider determinants of poor mental health and wellbeing especially in vulnerable individuals, groups and communities.

What difference have we made so far?

The previous Mental Health Strategy for Wiltshire ran from 2011 and led to a variety of activity to improve the approach to mental health and wellbeing services in the County. There is no room for complacency, but there have been significant enhancements to services in the intervening period. Some of the more recent improvements are outlined in the following paragraphs and an itemised list of services currently commissioned in relation to mental health and wellbeing is provided at Appendix 2.

We now have two places of safety, available 24/7, for all ages, spread across the county for those needing urgent assessment under section 136 of the mental health act. There is an additional place of safety in the Swindon area which can be utilised. This has seen the number of people held in police custody under section 136 of the mental health act halve since 2011/12 in both adults and children and adolescents. This means that people are being assessed and looked after in appropriate places – those suspected of a crime and a mental health condition in police custody, those with a mental health condition only in a mental health place of safety. We also have a service where a mental health professional can be present in police custody suites to help with identification of people who may be experiencing a mental illness.

We have significantly increased investment in liaison psychiatry in all three of our acute hospitals serving Wiltshire in recognition that 30-45% of patients cared for in this setting have a psychiatric component to their morbidity, especially unplanned emergency presentations. Psychiatric input improves the quality and safety of care, and enhances effective discharge and ongoing community care.

Our self referral community psychology service Least Intervention First Time ('LIFT') is consistently in the top ten Improving Access to Psychological Therapies (IAPT) services in the country. We have a growing range of other initiatives that foster mental health and wellbeing such as Wiltshire Wildlife, Artlift, Greenspaces, Health Trainers, free swimming for school children in the holidays, Wiltshire school bullying video, mental health first aid training, day centre and employment support and we are committed to continue to invest in and support these and similar activities.

Where possible, individuals with mental health problems are treated in the community as this supports long term recovery, is more cost effective, preferred by patients and allows for building of community resilience and reduction of stigma and discrimination. The scope for improving decision making on whether to treat using an inpatient mental health service or within the community will be further explored. We are consistently achieving the NHS target for the proportion of people who are promptly followed up after discharge that were treated using a Care Programme Approach.

We currently commission a range of specialist mental health community services which include:

- Vocational
- Social inclusion
- Statutory and generic advocacy
- Community support
- Supported housing schemes

Residential care placements are purchased from a variety of providers, and provide accommodation with care and support for the most vulnerable service users, many of whom have long term and enduring mental health issues. Except in a few cases it is always our intention to enable people to move onto less supported options and living independently in the community.

Psychiatric input improves the quality and safety of care, and enhances effective discharge and ongoing community care.

The development of these services to meet the future needs of the people of Wiltshire will be examined and set out in a Joint commissioning strategy.

In 2014 Avon and Wiltshire mental health partnership Trust (AWP) is commissioned by Wiltshire Clinical commissioning group to provide secondary clinical services and the mental health social work service is provided by Wiltshire Council. Additionally there are projects commissioned by public health to promote wellbeing and to deliver on the prevention agenda. A full list of these can be seen in the table at Appendix 1. Wiltshire CCG and AWP have agreed a local Commissioning for Quality and Innovation (CQUIN) for 2014/15 which is a set of actions and targets for improving service delivery.

The success of our approach so far is illustrated by the results of the national subjective wellbeing annual population survey 81.2% of respondents said they were satisfied with life, 72.8% had been happy yesterday, with 34.5% experiencing anxiety the previous day. These statistics show an improving trend and compared well against the national average.

What will we seek to improve?

What will we seek to improve?

To achieve the outcomes described on page 4 will require a holistic approach which touches on all aspects of a persons' life not just their medical needs and a recognition of the benefits of good quality housing, employment and supportive relationships.

It is important to identify and fill any gaps between public health and prevention and the primary and secondary mental health services in order to ensure the ongoing care of people with severe and ongoing mental health issues but who are not ill enough to meet current eligibility criteria for secondary care. There is a national drive to improve the number of people with mental health who are in employment (national figures indicate that only 1 in 10 are currently in employment) and it is important to determine what support can be provided to assist people in achieving their potential.

In order to deliver on our aim for Wiltshire, we will focus on some key areas for development. These priorities have been informed by the outcomes of the stakeholder and service user focus groups, local and national policy development and the evidence of need in the Joint Strategic Needs Assessment.

1. Prevention and early intervention (including perinatal mental health)

- Ongoing support and education in acquiring life skills such as parenting, employment, aspiration, self-direction, participation, engagement and healthy lifestyle choices around eating, exercising and smoking.
- Recognise and innovate around known rising triggers to poor mental health, especially loneliness, unemployment, boredom, alcohol and drug use and self-harm.
- Create better signposting to resources and education that promote and support mental health and wellbeing, including volunteering, leisure and physical activity opportunities. This will include an information and advice portal currently being commissioned.
- Further develop the evidence base around mental health in Wiltshire to improve our understanding and inform service development (for example to gain a better understanding of excess mortality for people aged under 65 with psychosis).

2. Promoting emotional wellbeing and tackling stigma and discrimination

- Together with our partners, we will work with communities to ensure community life in Wiltshire supports mental health and wellbeing by promoting better understanding and awareness of mental health issues to reduce stigma.

3. Personalised recovery based services with a wellbeing perspective

- Provision of flexible preventative, support, education and treatment pathways, providing service users with the tools and confidence to manage and sustain their recovery and wellbeing.
- Explore the provision of increasingly diverse prevention, support, education and treatment pathways to maximise inclusivity for every type of mental health disorder. Our model will be that of a Recovery College where we aim to educate the service user to understand their own health issues and aid themselves in a journey of health and wellbeing. For example to provide specialised employment support for those with autism, or arts based therapy for those with chronic neuroses and school based mental health around social networking, emotional learning, bullying and violence. This could include options for peer support programmes.
- Care for people close to home or their place of choice ensuring continuity of care where possible and appropriate.

4. Effective and efficient use of resources to ensure value for money

- Interdisciplinary working, training and care between mental health, emergency, prison and probation services.
- Review 'out of hours' service provision to ensure that people can access to the right type of care or advice whenever the need arises. Consider how improvements can be made across the whole system in order to minimise the need for out of hours.
- Implementation of the improvements outlined in the AWP CQUIN.
- Continue to work closely with our partners to ensure that care at times of crisis is appropriate and that the government Crisis Care Concordat (Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis) is implemented as appropriate across the county.

5. Closer collaboration with service users, families and carers in the development of services

- Undertake analysis of gaps in service for specific areas of need and explore options for further development of services where gaps exist. Areas might include: ADHD, personality disorder, provision of whole person services where a dual diagnosis exists, post-traumatic stress disorder, autism, veterans, perinatal/ parent-child health, prison/ probation mental health.
- to evaluate the ease of access and spread across the county of our services both acute and preventative, especially as many vulnerable individuals do not have independent transport, and respond accordingly.
- a commitment to assess and respond as appropriate to unexpected but significant new need and demand.

6. Joint working with a wider group of statutory services

- Build on current collaboration between specialist mental health services, and partners involved in the wider determinants of wellbeing such as housing, employment, education, money advice, recreation, leisure and physical activity, psychological therapies, carers/families support groups, community and voluntary sector. This is of particular importance in ensuring positive outcomes for those with complex needs.
- Wider multi-disciplinary teams who work together to achieve positive outcomes for those with mental health issues and their families. Increased access to and utilisation of specialist knowledge including non-health professionals and carers/family members, clear pathways to access mental health assessment and advice.
- effective use of information technology, including data collection and sharing of information.
- Implement multi-agency mental health first aid training for staff with public facing roles to provide greater awareness of how to identify and deal with mental health issues without causing escalation.
- A clear and robust interface with Learning disability services.
- Ensure clear pathways through primary and secondary mental health services.
- Multiple assessments where much of the information is already known.
- Share and keep up to date good practice, skills, knowledge and relationships across teams, across disciplines, across employers, across the county, including modern technology, nationally delivered applications and assisted technology with professionals skilled in how to promote and use them.
- Continue to build robust safeguarding mechanisms, but also to promote safeguarding for internet and social media use, especially with more vulnerable groups.
- Ensure that services and resources are provided in such a way they are accessible to our urban and rural communities across the county.

Other Priority Areas

Suicide and self-harm
Our primary objectives will be to:

- save lives
- interrupt the cycle of self-harm and suicide.

We will work to enhance protective factors and to reduce risk factors for suicide as outlined in the Suicide and Self Harm Prevention Strategy. We will provide people with support and encouragement to look after their mental health and wellbeing, one of the main risk factors for suicide. We will aim to provide evidence-based care for those affected by self-harm and suicide.

Military and Veterans
The Wiltshire Council Business plan has an action to build on the work of the Military Civilian Integration Partnership and work closely with other partners to ensure that the right services and infrastructure are in place to support the forthcoming rebasing programme.

We will ensure that the mental health and wellbeing needs of the military and their dependent population as well as veterans are considered in the development of the commissioning and delivery plans which support this strategy.

Accommodation and transport

- Complete implementation of any remaining relevant recommendations from the supported housing review
- continue to work with partners to assesses and address accommodation needs and provision
- work with partners to explore ways of addressing the barrier lack of transport presents to people getting jobs and thus sustaining their mental wellbeing, and respond accordingly.

Safeguarding

Helping to keep service users, their families and local communities safe from violence, abuse or neglect is essential when providing care for people with mental health problems.

We will work to help people recognise and deal with risks to themselves or others as confidentially as possible.

We will ensure that our safeguarding arrangements are underpinned by:

- Up to date policies and processes to safeguard children and adults at risk and to protect the public
- Staff trained in local safeguarding procedures
- Board level leadership and a specialist team that provides advice and support for practitioners in safeguarding people within their practice
- Active membership of local safeguarding and public protection multi agency partnerships working together with other agencies
- Listening to the safety concerns of service users and carers, families and communities.

What resources will we make available to deliver this strategy?

In 2013, across all agencies we spent around £66.3m on services relating to mental health and wellbeing. This strategy focusses on doing things differently and improving the way we work together to improve outcomes for people. We will continue to work together to find ways of using the money we spend to have the greatest impact on our aims for Wiltshire.

How will we know we have made a difference?

We will use a variety of quantitative and qualitative methods to assess the success of this Strategy, and these will focus on achieving positive outcomes for service users, patients and communities. This will include utilising established performance and outcomes frameworks and service user and patient feedback. Success will be regularly monitored through the Wiltshire Council Mental Health and Wellbeing Steering Group and the Mental Health Joint Commissioning Group with escalation via the Health and Wellbeing Board where appropriate.

References

The following documents have informed the development of this service specification:

- Wiltshire Joint Health and Wellbeing Strategy 2013-2014.
- NHS Wiltshire CCG five year strategic plan 2014-2019
- Wiltshire Council Joint Strategic Needs Assessment. Mental Health. 2013-2014.
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- New Horizons: towards a shared vision for mental health, 2009
- DH Strategic Commissioning Framework for Mental Health 2009-2014
- High Quality Care for All - NHS Next Stage Review Final Report 2008
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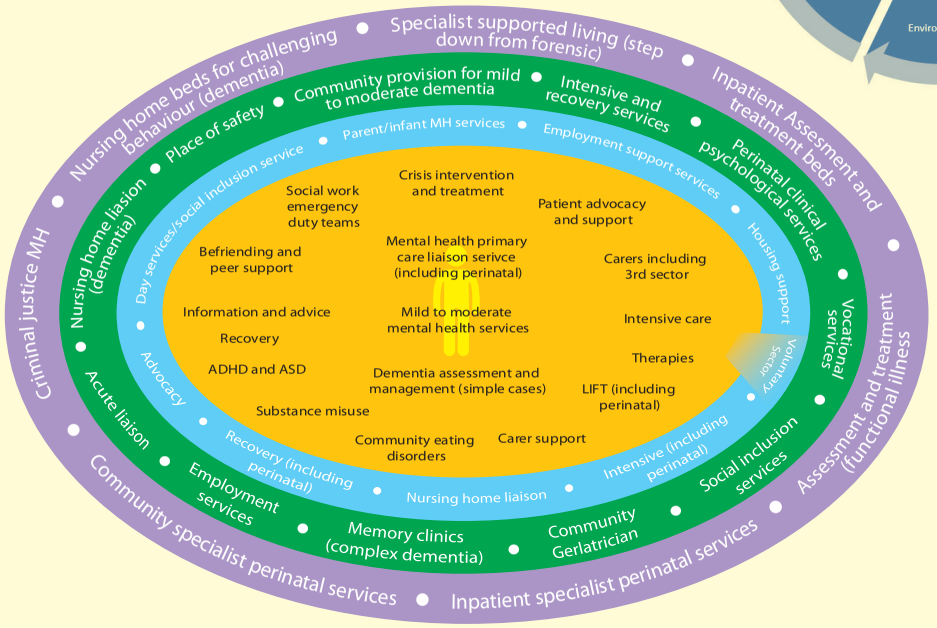
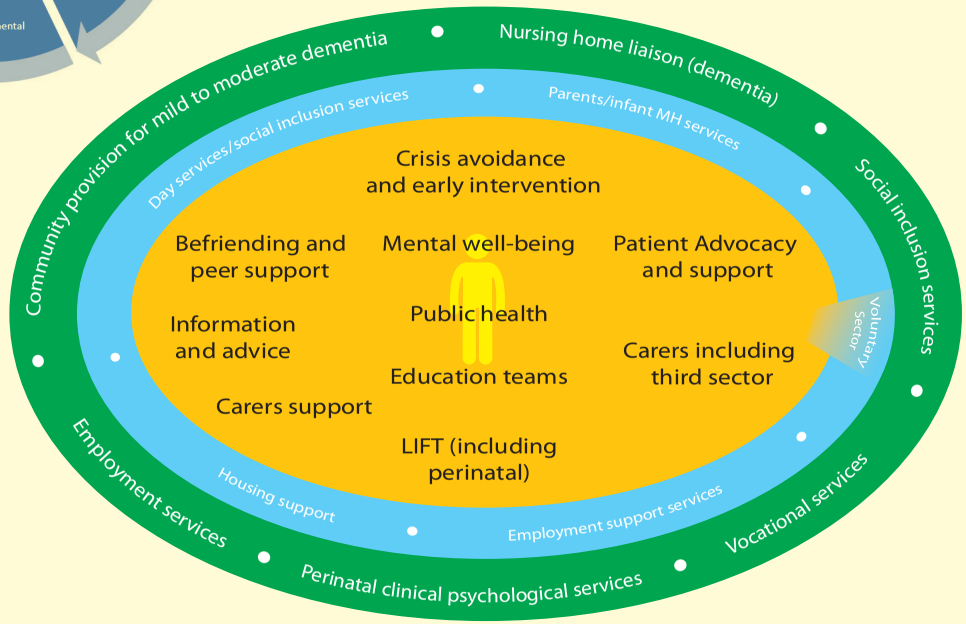
- ONS: Estimates of subjective well-being from the first annual experimental Annual Population Survey (APS) 2013
- Modernising Mental Health Services in Bristol
- Guidance for commissioners of acute care – inpatient and crisis home treatment 2013.
- Behind Closed Doors, Acute Mental Health Care in the UK. The current state and future vision of acute mental health care in the UK, Rethink
- Mind. Listening to experience. An independent inquiry into acute and crisis mental healthcare. 2011.
- Refocusing the Care Programme Approach. 2008
- Time-to-Change: Inspiring people to work together to end the discrimination surrounding mental health
- Equality Act 2010: What do I need to know as a carer? 2010
- The Mental Health Capacity Act
- Care Quality Commission. Essential standards of quality and safety. What providers should do to comply with the section 20 regulations of the Health and Social Care Act 2008. 2010.
- Carers and Confidentiality in Mental Health 2004
- DH. Mental Health Promotion and Mental Illness Prevention, the economic case. 2011.
- HM Government. Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis. Feb 2014
- NHS England Parity of Esteem Programme
- Wiltshire Dementia Strategy, Wiltshire Children Emotional Health and Wellbeing Strategy, Wiltshire Suicide and Self Harm Prevention Strategy

Future health and care model
Mental Health

Managing ill-health



Establishing and sustaining wellness and independence



Statutory responsibilities - e.g. Deprivation of liberty (DOL) and safeguarding

Appendix 2 - Current services commissioned in Wiltshire

This section outlines the current commissioned services for Adult Mental Health service users in Wiltshire.
Wiltshire Clinical Commissioning Group

Service	Provider	Jointly Commissioned	Description	Comments
Improving Access to Psychological Services (IAPT)	AWP	No	Primary Care Psychology delivered in the community, anyone can self-refer into the service.	The service is delivering all the national targets. There could be more scope in the future to further develop the service and mainstream it to reduce demand on secondary, specialist mental health and acute care services.
Specialist Mental health Services	AWP	No	Services include adult mental health services and dementia services	Historically there have been concerns about the quality and performance of the services provided. As a result AWP have undertaken significant change and the CCG are working hard to ensure that the improvements delivered continue and are built on
Dementia Diagnosis and Prescribing in Primary Care	GPs	No	The diagnosis and prescribing and on-going care for patients with 'simple' dementia within primary care.	This is a new service which is being commissioned with GPs via a Service Level Agreement managed by the local NHS England Area team. The aim is to ensure that dementia is diagnosed and treated more quickly going forward.
Autistic Spectrum Disorder (ASD)	Three providers via AQP	No	Assessment and diagnosis of ASD	The three providers are AWP, ADRC, (Autism Diagnostic research Centre) and SEQUOL. Of the three providers AWP delivers the majority of work. Commissioning arrangement are being reviewed in 13/14.
ADHD	AWP	No	Service for assessment, diagnosis and care based on a shared care protocol with Wiltshire GPs	The service is currently spot purchased with AWP. Work is progressing to develop a local service based on a shared care protocol with GPs.
AWP CHC / Specialist placements	Various including AWP	S117 is jointly funded	These services comprise of numerous individual contracts to meet the needs of individual patients	These services are commissioned by the CHC team, not the Mental Health Commissioning team.
Two nursing home liaison nurses Two STAR liaison nurses	AWP	No	Community Liaison services to aid with community transformation and to modernise services prior to the Older people's MH service redesign work being taken forward.	The funding is for 12 months only as it is envisaged that when older people's MH services are redesigned more capacity will be made available in the community.
Eating Disorder services, (Tier 3)	Oxford Health	No	Community Eating Disorder services.	Tier 4 services are now commissioned by Specialist commissioning, hosted by NHS England

Appendix 2 - Current services commissioned in Wiltshire

This section outlines the current commissioned services for Adult Mental Health service users in Wiltshire.

Wiltshire Clinical Commissioning Group - continued

Service	Provider	Jointly Commissioned	Description	Comments
Eating Disorder services, (Tier 3)	Oxford Health	No	Community Eating Disorder services.	Tier 4 services are now commissioned by Specialist commissioning, hosted by NHS England
CAMHS Tier 3	Oxford Health	Yes	Community support for more complex mental health difficulties. Model of provision includes an outreach service (OSCA), CAMHS for children and young people with a learning disability and a specialist Family Assessment and Safeguarding Service (FASS) to support LA decision-making on whether children can safely remain with their parents.	Tier 4 adolescent inpatient facility at Marlborough House in Swindon is now commissioned by Specialist Commissioning, hosted by NHS England
Rape and sexual abuse support for adult women and men	Revival	No	Providing a non-judgemental, confidential, safe and supportive atmosphere in which you will be given the time and space to explore your present in relation to your past	
Community-based music therapy service working in the field of adult mental health	Soundwell	No	All sessions are participatory and user friendly - people have a wide selection of accessible, multicultural instruments to use. People do not need to have had any previous musical experience to participate in sessions	

Wiltshire Council - Mental Health

Service	Provider	Jointly Commissioned	Description	Comments
Mental Health Social Work service	Wiltshire Council	No	Providing AMHP duties to all residents and social work to service users known to AWP. Two teams -46.93 FTE staff.	Setup in 2013 following disaggregation from AWP. Sits within Adult Care & Housing Operations Service area.
Specialist Mental Health Housing Team	Wiltshire Council	Yes (agreement for one post)	Providing a bridge between housing and mental health services. 2 FTE's	Staff are based within housing team but line managed by the Specialist Commissioning and Safeguarding Team/
Statutory Advocacy services provided	SWAN	No	Provision of a statutory service - independent mental capacity advocates IMCA and IMCA DOLs and Independent mental health advocates IMHA.	
Generic Advocacy services	SWAN	Yes	Provision of generic advocacy service aimed at vulnerable people which have a particular focus on safeguarding issues.	The NHS complaints service came to Wiltshire Council on 1st April 2013

Community based services

Vocational Services (DCS0153)	Richmond Fellowship	Yes	A countywide service to improve the confidence, training and skills of service users to achieve work ambitions.	Extension agreed to 31st March 2015
Day Service (DCS0381)	Alabare Include	Yes	Mental Health day services to improve mental wellbeing. The services support personal recovery, increasing social inclusion and support to access mainstream services.	This contract runs from 1st August to 31st July 2013. An 18 month extension to 31st March 2015 has been agreed.
Intensive Community Support Service (DCS0500)	Together	No	A service for adults that require support of a 3-24 month period before transitioning to less supported services.	
Mental Health information and advice service (DCS0440)	Alabare Include	No	Management of a website and directory of resources, delivery of mental health first aid training and number of awareness events.	This contract runs from 1st August to 31st July 2013.
User engagement	WSUN – our time to talk	No	A service user group for people who use mental health services in Wiltshire.	

Appendix 2 - Current services commissioned in Wiltshire

Accommodation based services

Service	Provider	Jointly Commissioned	Description	Comments
Supported Housing	Various providers (DCS0181 0 Rethink)	No	14 Supported Accommodation schemes spread across the county. All deliver a low level of housing related support to prepare people for independent living in the community.	Mental Health Supported Housing Review was completed in February 2013.
Residential/ Nursing Care for Adults of Working Age / Older People	Various providers	No	Many placements are spot purchased due to the complexity of needs AOWA Placements funded by Wiltshire Council are managed through a weekly panel. OA Placements are funded by locality panels to block contracted beds or spot purchased beds in complex cases	Accreditation Scheme - Eight providers have been accredited. The scheme has been developed to ensure quality standards and build relationships.
Care and support at home	Various providers	No	Some packages are spot purchased due to the complexity of needs. There are commissioned providers covering a geographic area in Wiltshire under the H2LaH scheme.	

Service	Provider	Jointly Commissioned	Description	Comments
CAB Debt management Project	CAB		Since September 2011, Wiltshire Citizens Advice has provided a one day per week dedicated debt advice service for the service users of Red Gables in Trowbridge. The aim of the project was to improve the mental wellbeing of individuals and to help them to manage their financial affairs themselves.	For 2013/14, CAB will deliver the service across Wiltshire, taking referrals from AWP Recovery Teams
Mental Health First Aid Training	MHFA accredited trainers		Public Health has commissioned Mental Health First Aid (MHFA) training courses which are made available to frontline staff that are most likely to come across people at high risk of developing mental health problems, such as Citizens Advice Bureau debt advisors, housing association staff and those working with older people living in very rural communities. MHFA provides a basic understanding of common mental health problems to enable those who are being trained to identify symptoms and to support someone who is having difficulties in seeking professional help.	
Books on Prescription	Wiltshire Libraries		Public Health commissions Wiltshire Wildlife Trust to provide a "green gym" service. Anyone with mental health problems can be referred (by their GP) to this service where they will be able to attend regular group sessions of conservation activities such as woodland management or countryside walks.	
Wellbeing Project	Wiltshire Wildlife Trust			

Wiltshire Mental Health and Wellbeing Draft Strategy

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Clinical Commissioning Group

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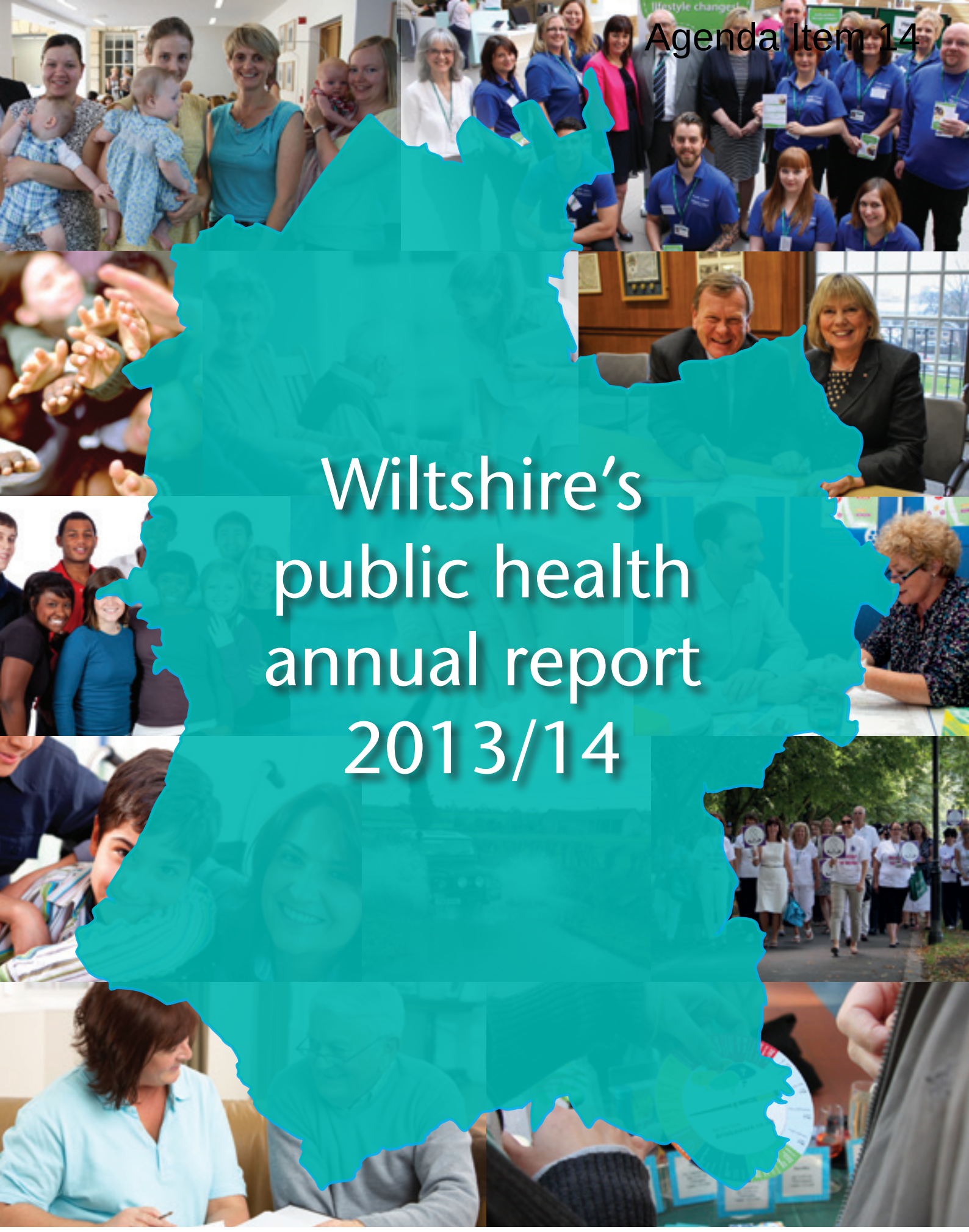
2014 - 2021



Wiltshire's public health annual report 2013/14

Wiltshire Council
Where everybody matters

Welcome to the public health annual report for 2013-14

As the Director for Public Health for Wiltshire I have a statutory duty to produce an annual report on the health of our local population, to account for public health activity and to chart our progress.

Public health transferred from the NHS to the council on 1 April 2013 and this is our first report.

Our first year following integration into the council has brought with it huge opportunities to improve health outcomes. This report looks at what we achieved, as well as the wider public health workforce and how we will tackle the challenges facing us locally.

My team and I have been welcomed into the council by Leader, Jane Scott, her cabinet and by my fellow corporate directors. The public health team has become part of the wider council family and, as part of that bigger team, we have strengthened our commitment to delivering high quality public health services to our communities and to improving health outcomes for people living in Wiltshire.

We have worked hard to maximise the opportunity provided by the Health and Social Care Act 2012 and to work with our new council colleagues and to maintain links with colleagues in the NHS – both in the Clinical Commissioning Group and our local acute trusts.

While there is still more to do, I am confident that in Wiltshire we have developed a clear vision for public health on which to build in coming years.

The last year has brought us challenges and our new public health system was tested with the measles outbreak and significant flooding during the winter of 2013/14, but it was also a year of success.

This report summarises some of our key achievements in 2013/14 and I hope you enjoy reading about our work. The success we have had would not be possible without the support of my dedicated team, cabinet members, colleagues and partners to whom I am truly grateful.

Maggie Rae

Maggie Rae
Director of Public Health and Corporate Director
Wiltshire Council

What is public health?

Public health is helping people to stay healthy and protecting them from threats to their health. We want everyone to be able to make healthier choices, regardless of their circumstances, to minimise the risk and impact of illness.

There are three areas of public health

- **Health improvement**
- **Health protection**
- **Healthcare services**

Responsibility for public health was moved from the NHS to councils by the Health and Social Care Act 2012. Councils now have a duty to improve the health of the people in its area.

To achieve this, we commission a range of services from providers from different sectors. We work with Wiltshire's Clinical Commissioning Group (CCG) and representatives of the NHS Commissioning Board to create as integrated services as possible.

Other ways we are working to improve the county's health is by looking at planning and health policies, developing key partnerships with other agencies and by enabling a diverse provider market for public health improvement activities.

Our aim is to integrate public health into the heart of all public services which will help us to improve everyone's health. We are committed to improving the health of the most vulnerable as a priority.

What does public health do?

Public health works to improve health outcomes for local populations by encouraging people to live healthy lifestyles and to help prevent them from becoming ill.

We do this by working with partners including GPs, schools, our communities, the military and others to educate people about the importance and impact of their lifestyle choices on their health.

This can be encouraging people not to smoke, to cook healthy balanced meals and to exercise regularly.

Many people are 'doing' public health without realising it - leisure centre staff are encouraging people to maintain or improve their health, social workers are working to ensure people live independently in their own homes while they are able to do so.

As part of the council's wider team we are now able to work more closely with these groups and others who directly or indirectly support our work.

Who are we?

We are a small team of public health consultants, specialists in public health and a range of other roles. The team works closely with colleagues in adult social care, housing, communities, libraries and communications.

We believe success will be making a real difference to people's lives. Success will mean different things to different people. We believe through working together we can achieve our aims to ensure people in Wiltshire live long, healthy and happy lives. That will be success.

Our wider public health team

It is now widely recognised that staying active and exercising is an essential part of being healthy. To support this work, leisure services have joined us and become part of our wider public health team.

This has been another exciting opportunity to maximise the potential of public health and improve health outcomes. We have set up a programme board which is responsible for integrating these two important services.

Our work focuses on helping people to live longer and healthier lives and to remain as independent as possible for longer. Working to reduce inequality in the provision of health services is also a priority.

Helping people to live healthy lives and to exercise more is crucial to reducing obesity, long term disease and to help our growing older population to enjoy a better quality of life.

Dr Steve Rowlands, Chair of Wiltshire's Clinical Commissioning Group and Council Leader, Jane Scott, Chair of the Wiltshire Health and Wellbeing Board signing the Joint Health and Wellbeing Strategy

Bringing together public health and leisure means we can provide our local population with the best possible support for achieving positive health outcomes and, by reducing demand on health services, ensure the future sustainability of our public services.

How are we assessed?

The Public Health Outcomes Framework (PHOF) was introduced in April 2013 and sets out standards for public health. It details outcomes and indicators which help us monitor and assess how well we are doing to improve and protect the public health of our communities.

There are more than 60 indicators, which contribute to two main outcomes – how long people live and how well they live at all stages of life.

More information can be found at: **www.phoutcomes.info**

Annual Health Profile: **www.apho.org.uk/resource/item.aspx?RID=142340**

Our vision and priorities

We are required by government to:

- provide appropriate access to sexual health services
- protect the health of the population and ensure plans are in place to achieve this
- ensure NHS commissioners receive the public health advice they need
- take part in the National Child Measurement Programme
- provide and promote NHS Health Check assessments
- provide elements of the Healthy Child Programme.

Our wider work programme focuses on protecting and enhancing the health and wellbeing of our communities by working together to make Wiltshire healthier.

More information can be found at:

www.gov.uk/government/publications/healthy-lives-healthy-people-update-and-way-forward

Our challenges

Wiltshire people are generally healthy – this is measured by life expectancy.

Current life expectancy for men is more than 80 years, at 80.4, for the first time. For women it is 83.9 years. The regional/national average is 79.2 years for men and 83 years for women.

We are all living longer as life expectancy continues to rise. Our work is to ensure people are able to continue to live active and independent lives.

We know there are variations in life expectancy across Wiltshire, with levels of deprivation influencing life expectancy.

We are working with communities where life expectancy is lower to improve their chances of leading healthy and active lives. We also work to prevent premature deaths - people who die before the age of 75.

Healthy life expectancy is a measure of how many years on average a person can expect to live in good health. These years can be measured from birth or from a given age such as 65.

Life expectancy

Life expectancy in Wiltshire is statistically significantly higher than in England and similar to the South West. Having exceeded 80 years for the first time in 2009-11, male life expectancy in Wiltshire has risen further to 80.4 years in 2010 -12. This is more than five years longer than in 1991-93 when it was 75.2 years. Female life expectancy reached 83.9 years in 2010-12 which was an increase of 3.7 years since 1991-93.

We know the biggest killers are cardio vascular disease, cancer and respiratory disease and we work with communities and other healthcare providers to encourage early diagnosis and prevention.

For more information about the Health and Wellbeing in Wiltshire please see the Joint Strategic Assessment for Health and Wellbeing:

www.intelligencenetwork.org.uk/health/jsa-health-and-wellbeing

What has happened so far

Our first year as part of the council has been busy and varied.

Work included dealing with and successfully containing a measles outbreak in April 2013.

We were able to test the resilience of our new working arrangements and worked with staff across the council and external partners to minimise the impact on the public and to protect public health.

We updated the Joint Strategic Assessment for Wiltshire 2013-14 which collates data from across the council and public sector partners and highlights key issues facing the area.

We supported around 2,500 people to stop smoking and ran a diabetes road show with the CCG, which helped 285 people.

In summer 2013, the council published its business plan for 2014 to 2017. For the first time public health is a key part and integrating public health into the heart of public services is now one of the council's 12 key actions.

The newly established Wiltshire Health and Wellbeing Board published the first Joint Health and Wellbeing Strategy which sets out how it will work to ensure people have the support they need to live longer healthier lives.

> The integration of public health at the heart of all public services is one of the 12 key actions for the council during 2014-2017 and this will help the council deliver the vision and priorities.

The aims of the strategy are to enable people to:

- Live longer
- Live healthily for longer enjoying a good quality of life
- Live independently for longer
- Live fairly – reducing the higher levels of ill health faced by some less well-off communities

Our key local themes and priorities are:

- Prevention
- Independence
- Engagement
- Safeguarding

More information about the Health and Wellbeing Board strategy can be found at:

www.wiltshire.gov.uk/healthandsocialcare/jointhealthandwellbeingstrategy.htm

What we achieved in 2013-14

Public health taking action in our communities

The second local community area joint strategic assessments (CA JSAs) were presented to communities across the county in February 2014. Partnership events were hosted by our 18 area boards and attended by more than 2,000 people.

Local community data was provided covering health and wellbeing, housing, environment, economy, leisure, children and young people, transport, community safety and arts and culture.

The events brought local people together to decide their local priorities and to agree plans and projects for the next two years. Many ideas came from the events and the agreed priorities and networking opportunities provided will help us build stronger, more resilient communities.

For the first time the community area JSAs are available through a new website: www.wiltshirejsa.org.uk, enabling communities to access data relating to their area.

Following the CA JSA events there has been interest in further sessions for older people, children and young people and housing tenants.

> Between February and April 2014, 18 events took place and were attended by more than 2,000 members of the public and those representing community groups.

Website: www.wiltshirejsa.org.uk

The Big Pledge

The Big Pledge encouraged people across the county to pledge to do something to improve their health and wellbeing.

The county wide initiative, in June 2014, covered everything from personal pledges to be more active, give up smoking, volunteer in the community to groups and organisations.

Some communities committed to become dementia aware and friendly communities, others pledged to arrange events such as the Big Walk and Big Tidy. Individuals completed physical or mental challenges, raised money, or made a difference to their local community through volunteering.

Health improvement

Early intervention

We are committed to ensuring our children have a healthy start in life. Wiltshire has been chosen to be an 'early intervention place' as part of a project led by the Early Intervention Foundation to establish best practice.

We are involved in identifying opportunities for shared health and early years education outcomes for children up to the age of five. This approach supports professionals from different agencies to work more closely to improve outcomes for families.

Providing our children with the best start in life

Work to improve health outcomes begins at the very start of pregnancy. Obesity in pregnancy carries significant risks to both mother and baby. We are working with local maternity services to implement SHINE, an evidence-based healthy lifestyles support programme for pregnant women. Midwives will be trained to provide the group based programme to motivate and help women to make healthy lifestyle choices.

Birth environment audit

Where and how women give birth is important. An assessment of new parents was carried out and all birthing centres were visited. The information provided from the assessment was used to improve the service.

The work was carried out through the Wiltshire, Swindon and Bath and North East Somerset Maternity Strategy and Liaison Committee.

Breastfeeding

The number of new mothers breastfeeding continues to rise. We support the local Mum2Mum breastfeeding scheme which trains volunteers who have breastfed their own children, to provide advice and help to new mothers.

In 2013/14 more than 80 volunteers completed the accredited training course and are now supporting women on postnatal wards and in local children's centres across the county.

The council supported Children and Young People's Community Health Services in Wiltshire to achieve the UNICEF Community Baby Friendly Initiative award.

Winning this highly acclaimed award reflects the work we have done to improve the standards of care to support breastfeeding and parent infant relationships.

The council has also joined the national breastfeeding scheme. The scheme encourages more mothers to breastfeed when out and about by providing safe and welcoming environments for mother and baby.

Breastfeeding initiation rates in Wiltshire are consistently higher than the national and regional averages, and have remained above 80% since 2008/09. In 2013/14 Wiltshire's breastfeeding rate at six to eight weeks has increased to 49.3% - the same as the south west regional average and higher than the national average for England (45.8%).

Breastfeeding event

UNICEF Community Baby Friendly Awards photo

(PICTURE and caption FOR UNICEF Community Baby Friendly

Mum2Mum
Breastfeeding? Talk to a mum who has.

School years

The school nursing service is a vital part of how we improve the health and wellbeing of school aged children.

Every school in Wiltshire has a named school nurse who supports children, young people and their families.

Our nurses hold weekly drop-ins at secondary schools where young people can go for information and advice. In 2014, public health invested an additional £74,000 in this programme to ensure we improve long term health and wider social outcomes for our children and young people.

Supporting new parents and children in the early years

Health visiting: All families with children under the age of five now have the support of a health visitor and the service also provides additional support to those families who need it.

The Family Nurse Partnership is a new service for Wiltshire, offering a voluntary home visiting programme for first time mums and dads, aged 19 or under. A specially trained family nurse visits young parents regularly, from early in pregnancy until their child is two years old.

Case Study

Our work in action: The early years nutrition project

We are helping children to start eating healthily as young as possible by working with 150 nurseries that provide all day care for young children.

We are working to improve standards and are working with children's nurseries to ensure children are eating healthily. Food provided at day care centres was assessed and nurseries given advice on how they could improve their menus. All the nurseries involved acted on advice given and made simple yet effective amendments to their menus, helping us to reduce childhood obesity in the county.

29.4 % Almost one in three children in Year 6 is overweight or obese

One in five children in reception is overweight or obese 21.3 %

Reducing childhood obesity

The National Child Measurement Programme (NCMP) records the height and weight of reception year children, aged four and five, and Year 6 pupils, aged ten and 11.

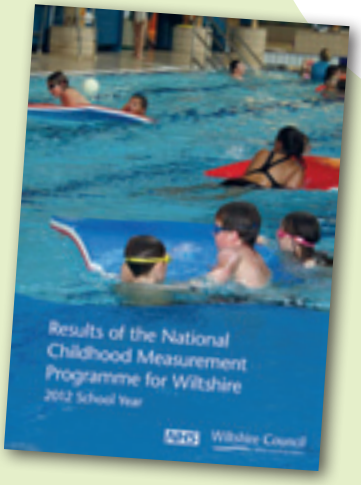
The results for 2013/14 showed the increase in overweight or obese reception age children appears to be stabilising.

Lower numbers of obese and overweight children were recorded in Year 6 during 2012/13 compared to the previous year.

Wiltshire has lower percentages of obese and overweight children compared to England or the south west.

Around one in five pupils in reception and one in three in Year 6 across Wiltshire were found to be obese or overweight. This equates to 1,053 obese and 1,247 overweight children across the county.

Lower numbers of obese and overweight children were recorded in Year 6 during 2012/13 compared to the previous year.



The annual NCMP data has been available since 2005 and means we can target resources at areas where children and their families are in most need of support to achieve healthy weight and growth.

Sexual health and wellbeing

Our work to reduce the number of teenage pregnancies and improve young people's sexual health has continued to be successful.

Evidence shows that having children at a young age can have a negative impact on young women's health and well-being and limit education and career prospects.

Our teenage pregnancy rate continues to fall. In 2012 there were fewer than 200 teenage conceptions (ONS 2014) for the first time since the baseline was set in 1998.

This is a rate of 21.5 per 1,000 - our 2014 target was to lower the rate to 23 conception per 1000 females aged 15-17 and compares to a rate of 35.0 in Sept 2007 and 293 conceptions in 2007. In 2011 there were 211 conceptions showing the number of teenage pregnancies has been falling year on year since 2007.

The work we're doing is also having a positive impact on the number of girls under the age of 16 becoming pregnant.

The number has fallen to 42 in 2012 compared to 48 in 2011 and 55 in 2010.

The uptake of long acting reversible contraception (LARC) is a key part of our strategy to reduce unplanned pregnancy across all ages. LARC is considered the most effective form of contraception as it does not rely on remembering to take or use contraception to be effective.

The prescribing rate for LARC in Wiltshire is 76.8/1000 women, significantly higher than the national rate of 49/1000 and higher than the south west rate.

Wiltshire continues to provide the strategic leadership for the South West Improving Access to Contraception Programme.

Maggie Rae taking part in the Walk in White which launched the 'No Excuse for Abuse' campaign in September 2013

The Chlamydia screening programme targets young people aged 15-24 who are most at risk of Chlamydia infection.

Wiltshire is maintaining the high detection rate with 9.3% of young people who take the test found to be positive. We also have the highest performing service in the south west for contacting partners of patients with a positive result.

The ZeeTee campaign, challenging homophobic language and bullying in schools has now been run in 10 secondary schools with 25,000 students, teachers and members of the public signing a pledge for zero tolerance of homophobia and transphobia.

Healthy adults and later life in Wiltshire

Cardiovascular disease (cardiac, stroke, diabetes) is one of the leading causes of death in Wiltshire, accounting for approximately 31% of all deaths.

Recent data suggests that in Wiltshire over 15,600 individuals registered with GPs have coronary heart disease, more than 9,300 have suffered a stroke or TIA (mini stroke) and more than 69,000 have hypertension.

There are also individuals who have these diseases and conditions who have not been identified, or who could prevent these diseases occurring if they took action.

In Wiltshire during 2013/14, 20% of the population aged 40-74 was invited to have NHS Health Checks to assess their individual risk of cardiovascular disease.

More than 33,000 invitations were sent out by GPs and more than 14,800 people responded and had a NHS health check. The overall take up rate of 45 per cent

in Wiltshire was higher than the average for the south of England (41 per cent).

> NHS Health Checks in Wiltshire are paid for by Wiltshire Council - so they are free to patients and are offered by every Wiltshire GP practice.

A range of lifestyle services are also offered in Wiltshire which complement NHS health checks including stop smoking services, weight management services, Active Health physical activity programmes and health trainers.

It has been estimated that there are 7,000 people in Wiltshire who do not know they have diabetes. The implications are profound. Left untreated, diabetes can cause complex health problems.

> It has been estimated that there are 7,000 people in Wiltshire who do not know they have diabetes.

Of the 20,800 adults in Wiltshire who have been diagnosed with diabetes, approximately 90% of those have Type 2 diabetes.

We are working with NHS colleagues to improve the care of people with diabetes and to stop more people being diagnosed with Type 2 diabetes by increasing the population's awareness of the disease.

An annual diabetes summit started in 2012 aims to to improve healthcare for people with diabetes. In October 2013, we held a diabetes road show in four Wiltshire towns to provide diabetes risk assessments to the public.

A total of 285 people were assessed with half being recommended to visit their GP. The major risk factor for type 2 diabetes is being overweight and the main reason for referral was weight, as 40% were overweight, 22% were obese, and 9% were morbidly obese.

Diabetes roadshow with Maggie Rae, Dr Steve Rowlands and Cllr Keith Humphries

14,800 people had an NHS Health Check during 2013/14

Nearly 19% of Wiltshire's population is over 64

Health trainers

In 2014 we launched our innovative health trainer programme and it is now providing support to those who need it most across the county.

The aim is to provide one-to-one support to help people change and improve their health.

Following the success of the health trainer programme at HMP Erlestoke, Wiltshire Probation Trust, and Wiltshire Addiction Support Project (WASP), health trainers have been employed to work in each community area.

The 18 area boards supported the recruitment by encouraging local people to apply for the roles. The aim is to improve and protect the health and wellbeing of some of Wiltshire's most vulnerable adults and to reduce health inequalities.

The programme helps people to live healthier, more active and high quality lives by taking by supporting adults to:

- improve general wellbeing
- build self confidence and motivation
- be more active
- eat healthier food and be a healthy weight
- reduce or stop smoking
- drink less alcohol

All health trainers receive comprehensive training, completing the City and Guilds health trainer certificate before they can work with clients.

Our health trainers have a thorough understanding of the community they work in and work closely with staff in libraries, leisure centres, housing, health practitioners, children's centres and many other community groups and services.

This is an exciting new service and we now have health trainers in all community areas supporting the health and wellbeing of Wiltshire's adults.

"My biggest achievement is giving up smoking!"

"I can't believe the changes in my confidence from only six sessions, it makes me feel so good"

"I've cut down on eating rubbish I'm more active and feel better"

"I feel better and changing my diet has helped with my moods"

"The Health Trainer has given me incentive and motivation. I would not have done it without him. I didn't want to let him or me down!"

helping you to help yourself

Leading healthy lives

The Active Health scheme provides physical activity programmes for people referred by healthcare staff, including patients with obesity, musculo-skeletal problems and who require rehabilitation after a stroke and heart attack.

'Strength and balance' classes for older people are offered through the scheme. Active Health is provided by exercise professionals in our leisure centres in partnership with the NHS.

Three month programmes are tailored for each individual and available across the county in leisure centres and other local facilities at a concessionary rate.

During 2013-14, around 3,000 people were referred to the scheme, a third of those was due to a client being overweight or obese. One in five referrals was for impaired strength or mobility.

Results show patients are achieving significant improvements in strength, mobility, memory, thinking and mood.

> In Wiltshire, almost two-thirds of adults are estimated to be overweight and numbers are expected to continue to rise although recently the rise appears to be slowing.

In 2012 we introduced the slimming on referral scheme where GP surgeries can refer overweight patients for 12 weeks free classes at local Slimming World or Weight Watchers.

The scheme has proved successful with almost 2,400 patients referred in the first two years. Half of the patients attending classes lost at least 5% of their starting body weight. More than one in 10 lost 10% or more of their weight.

In the first two years of the slimming on referral programme, the total weight loss was a staggering 1,421 stones – almost nine tons.

Building on the success of the scheme, we now offer patients who do well a second period of 12 weeks free attendance at Slimming World or Weight Watchers.

Helping people to stop smoking

Smoking is the main avoidable cause of premature deaths in the UK. The impact of smoking tobacco reaches beyond individuals to their families and communities.

We have worked in partnership with Wiltshire Citizens Advice Bureau, Erlestoke Prison, People for Places pharmacies and NHS colleagues to help support people to stop smoking.

We have reached out to people by providing services innovatively through our libraries and leisure centres.

The Health Information and Support service (HISS) is a partnership project between Wiltshire Council (Library Service & Public Health), the NHS and Macmillan Cancer Support. The service is available at 12 libraries and provides information on healthy living, cancer and cardiovascular disease.

In 2013/13 the service dealt with 3964 enquiries, an 8% increase on the previous year.

A GP surgery advice project, a partnership between Wiltshire Public Health and Wiltshire Citizens Advice, has also enabled us to provide advice to patients registered at doctors' surgeries in deprived areas of Wiltshire.

In 2013/14 the project worked with 493 clients supporting them with advice on work, debt, housing and employment.

SMOKEFREE
WILTSHIRE

2013/2014
Stop Smoking Service
Health Outreach Events
(Number of individuals tests and given information)

Cholesterol	892
Lung	221
Blood Pressure	801
CO	780
Total referred to Stop Smoking Services	228

Wiltshire Stop Smoking Service supported over 4,500 individuals and 2,451 successfully to quit smoking in 2013/14.

Reducing the harmful impact of drugs and alcohol

We lead on preventing and dealing with the damaging impact of drugs and alcohol on individuals, their loved ones and the wider community.

Our work, in partnership with the Wiltshire Community Safety Partnership (WCSP), has continued to reduce the impact of drug and alcohol abuse in our communities.

We have developed a Wiltshire Drug Strategy Implementation Plan and a Draft Alcohol Strategy with the council's partners in the WCSP.

The successful implementation of significant new substance misuse services in both the community and at HMP Erlestoke has been well received.

This year we have supported two successful bids to Public Health England, to enable us to increase support for those in need. We invested to improve facilities offered by Action on Addiction, a local residential rehabilitation provider, and for Alabare Christian Care to open additional supported housing for people who are stable and on recovering.

During 2013/14 we secured a three year 'preparation for employment' service to support the recovery process and reintegration into society for those who are stable and approaching the end of their treatment.

A housing process has also been developed for those with substance misuse issues who are in treatment to provide them with stability and promote recovery. This has been achieved by bringing together the council's expertise in housing and public health.

The work by the Alcohol Liaison Nursing services has meant fewer hospital beds have been taken up in the Salisbury Foundation Trust, Salisbury and Royal United Hospital, Bath.

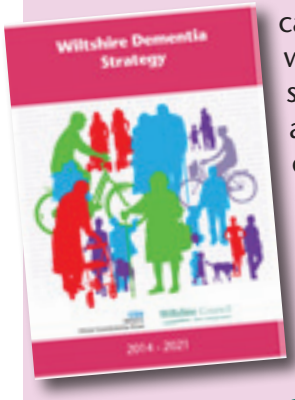
The services work with people with alcohol problems to ensure that community treatment services are being used where appropriate. This results in people moderating their drinking habits or using specialist services meaning they don't need to go back into hospital.

Over the last year we have also focused on preventing addiction and improving public awareness. We have extended alcohol identification and brief intervention work to GP practices and pharmacies to increase awareness of safer drinking levels in the wider population.

Dementia

Public Health has assisted in the development of the Joint Wiltshire Dementia Strategy by providing vital population data and strategic advice. Public consultation on the strategy ended in May and public health will lead on the dementia prevention work.

We have also been working to support and promote Wiltshire's 'Before I Forget' campaign which seeks to support area boards to make their communities dementia aware. We have developed a 'how to' toolkit for the campaign and we are providing support and advice as it rolls out across the county.



More information is available at: **www.wiltshire.gov.uk/healthandsocialcare/socialcareadults/healthandmedicaladvice/mentalhealthdementia.htm**

Falls

We continue to fund strength and balance classes throughout Wiltshire. We are looking to expand these and a primary falls prevention project by AgeUK.

The current Falls and Bone Health Strategy 2015-2020 will be revised following the results of our evaluation of existing primary falls prevention work and the development of a new system.

This will ensure a far more effective plan for Wiltshire is in place. Work is monitored by the Wiltshire Falls and Bone Health Group which includes our partners in Acute Trusts and the voluntary sector.

Health protection

Flooding

The first few months of 2014 saw some of the worst flooding across the country for several years. Wiltshire was badly affected, with 490 homes and 52 businesses flooded. Many roads were either partially or fully closed for two months.

Our new combined public health and protection service was central to the authority's emergency response. The emergency planning service coordinated an incident room and a 24-hour response capability throughout the two month period, whilst environmental health and public health officers visited homes and communities affected by flooding.


Harnham Water Meadows


Pitton


Bishopstone

Measles

In 2013 several cases of measles were recorded in Wiltshire, a number of which were linked to a gypsy and traveller site near Chippenham.

Many residents at the site were keen to protect their children with an MMR vaccination but they were unable to get to their GP during the day.

Measles spreads quickly, particularly in a close community such as a traveller site, and because of the large number of unvaccinated children the team arranged a vaccination clinic on the site itself.

A voluntary organisation with a double-decker bus visited the site every week as a mobile community centre. More than 40 residents, both adults and children, were vaccinated.

Health protection

Tick awareness campaign in Wiltshire

It's known that Wiltshire has a relatively high tick population. A campaign began in March to raise awareness and inform people how to avoid bites and how to remove ticks safely.

The awareness drive was supported by GP practices, pharmacies, schools, libraries, parish councils and promoted through the local media. Tick removal kits were provided for countryside volunteers.

Healthcare associated infections (HCAIs)

We work to prevent healthcare associated infections with NHS England, Public Health England and NHS Wiltshire CCG to maintain surveillance, promote infection control and to protect the local community against preventable infections.

A report is provided to NHS Wiltshire CCG on a quarterly basis and work is being undertaken to strengthen arrangements with local independent hospitals.

This will support the surveillance arrangements and check whether discharge information consistently includes the infection status of patients.

Sun and skin cancer awareness campaign

More people in Wiltshire develop skin cancer than in the south west and the rest of England.

Our sun awareness campaign is in its second year and events have been held across the county to raise awareness of the risks of skin cancer.

The council is reviewing its policy on sun awareness for outdoor workers and targeting children's centres and military families. A survey to assess awareness will help us plan future campaigns.

Maggie Rae and Cllr Keith Humphries

We also worked to raise awareness of the risks of excessive UV exposure. We assessed the cleanliness of tanning salons premises, maintenance of the equipment and compliance with sunbed regulations. Advice and guidance was given where there were minor safety issues and this was acted upon by the salon operators.

There are around 110 new cases of melanoma (skin cancer) per year in Wiltshire with approximately 25 deaths per year.

Warmer weather	Outdoor workers	Beach proximity

Healthcare services

Working in partnership

Effective partnership working has been key to the success that has been achieved over the last year and providing the best health outcomes for our communities.

The Memorandum of Understanding (MOU) between Public Health Wiltshire CCG has been reviewed. Health covers areas where public health and the CCG work together to deliver health improvement, healthcare and health protection.

The Health and Wellbeing Joint Strategic Assessment (JSA), developed by public health, has been used by the CCG to demonstrate current population status and needs.

The community area JSAs and engagement events were attended by the CCG as key partners. Public health has a representative on each of the three CCG locality groups. They provide public health advice and support to CCG issues and promote public health campaigns.

Public health is fully engaged with the CCG on quality in healthcare, advising the commissioner and acute trust providers and providing additional data. This includes bringing a population and advocacy aspect to reviews of clinical policies and the use of NICE guidelines, and providing evidence-based reviews of proposed services.

We have been working with Wiltshire CCG on its five year plan and have provided advice and support with the development of the strategy and, as the lead for the prevention aspect of the plan, will continue to work with the CCG to ensure this achieves the outcomes chosen.

Better value healthcare network

We are leading a multi-organisational group looking at the redesign of healthcare systems.

The group consists of social care, Wiltshire CCG, Avon and Wiltshire Mental Health Partnership (AWP), GPs and Healthwatch. The focus has been falls and bone health and designs for a new system will be presented to the Health and Wellbeing Board.

Wiltshire's work with this national group will help pave the way for a national framework. Further system redesigns are planned for the future.

Sexual health services

Under the Health and Social Care Act, public health commission a number of healthcare services inducing sexual health. Here are some key facts about the current sexual health services provided in Wiltshire.

867
Young people obtained free condoms via **No Worries! pharmacies**

462
Young people obtained free condoms through **primary care**

5900
Young people were tested for **Chlamydia** with 507 testing positive (8.7%) of these 176 were treated in **No Worries! general practices** and 82 treated via **No Worries!** in **community pharmacy.** The remainder were treated in either **CaSH** or **GUM clinics.**

452
Young people accessed **No Worries!** through primary care

83
Young people aged under 16 had a **sexual risk assessment** – six were referred to CSC for safeguarding concerns

No Worries!

Healthcare services

Fuel poverty

Warm and Safe Wiltshire, a new service, will provide affordable warm homes, reduce the risk of fire and falls in the home, reduce the number of winter deaths and hospital admissions related to cold conditions.

The new service will specifically target vulnerable households through an intelligence-lead approach supported by frontline health and social care professionals.

Warm & Well
a fitter home for a healthy future

The Wiltshire Warm and Well scheme provides heavily subsidised and in many cases free home insulation.

It will maximise the economic and employment opportunities available by promoting energy efficient homes to less vulnerable households, the "able to pay" customers and the wider public.

Case Study

Working with Wiltshire's businesses

The Food Standards Agency provided funding for councils to provide practical coaching sessions to small food businesses to help raise standards.

We were successful in securing funding to work with takeaway food businesses that had low food hygiene rating scores between 2013 and 2014.

The programme promoted positive outcomes through advice rather than enforcement. The number of takeaways with a high food hygiene rating score was increased reducing the risk of food poisoning.

A total of 77% of the businesses inspected following the coaching visit have improved hygiene standards.

For further information please read our 2012/13 annual report:

www.wiltshire.gov.uk/public-health-2012-2013-report.pdf

An event to encourage women to be more active was held in the Atrium at County Hall in September 2013. British Olympic skeleton bobsleigh champion racer Shelley Rudman, from Pewsey, supported the event with Maggie Rae.

Information about Wiltshire Council services can be made available on request in other languages and formats such as **large print** and audio.

Please contact the council
by telephone on **0300 456 0100**,
or email customerservices@wiltshire.gov.uk

Wiltshire Council
Where everybody matters

Wiltshire Council

Health Select Committee

23 September 2014

Local Authority Health Scrutiny - Guidance to Support Local Authorities and their Partners to Deliver Effective Health Scrutiny

Purpose of report

1 To highlight the key elements of the new Local Authority Health Scrutiny Guidance including the consultative responsibilities of the main bodies involved in governing health services.

Background

2 In June 2014 the Department of Health (DH) published guidance that explains local authorities' responsibilities as set out in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, and the policy background for the scrutiny of local health services. Local authorities are responsible for scrutinising local health organisations to ensure they are providing effective, efficient services and encourage improvement.

3 The guidance entitled *Local Authority Health Scrutiny – Guidance to Support Local Authorities and Their Partners to deliver Effective Health Scrutiny* is non-statutory but the DH states that the guidance 'needs to be conscientiously taken into account'.

4 The guidance includes a number of key messages which are reproduced in Appendix 1. The full guidance was circulated to all select committee members on receipt and is also available here.)

Main considerations

5 Many of the powers of health scrutiny described in previous legislation remain unchanged for local authorities. These include the power to:

- Review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services;
- Require information to be provided by certain NHS bodies about the planning, provision and operation of health services;

- Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions.
- Make reports and recommendations to certain NHS bodies and expect a response within 28 days.
- Set up joint health scrutiny committees;
- Refer NHS substantial reconfiguration proposals to the Secretary of State.

6 Duties on the NHS that are carried forward into the new legislation require the NHS to:

- Provide information about the planning, provision and operation of health services as reasonably required by the health scrutiny function;
- Attend local authority health scrutiny meetings;
- Consult on any proposed substantial developments or variations in the provision of the local health service;
- Respond to health scrutiny reports and recommendations submitted to them by the health scrutiny function. Where requested by health scrutiny a written response should be produced within 28 days (now a statutory requirement);
- Consult and involve patients and the public, which are in addition to the duties to consult with health scrutiny.

Key changes from the previous legislation

7 As commissioners or providers of public health services and as providers of health services to the NHS, services commissioned or provided by local authorities are themselves within the scope of the health scrutiny legislation.

8 The health scrutiny function rests with the Council and the Council may decide how it is discharged. In Wiltshire it has been agreed that this will be through the Health Select Committee.

9 Healthwatch or contractors may make referrals to the health scrutiny function, which should have a mechanism for dealing with them. The Select Committee assumes this responsibility.

10 The scope of the health scrutiny function has been extended to cover the full range of commissioners and providers of NHS-funded services, who are referred to as "responsible persons". The responsible persons are:

- Clinical Commissioning Groups (CCG);
- NHS England;
- Local authorities (insofar as they may be providing health services to CCGs, NHS England or other local authorities);
- NHS trusts and NHS foundation trusts;

- GP practices and other providers of primary care services (previously not subject to specific duties under health scrutiny regulations as independent contractors, they are now subject to duties under the new Regulations as they are providers of NHS services);
- Other providers of primary care services to the NHS, such as pharmacists, opticians and dentists;
- Private and voluntary sector bodies commissioned to provide NHS or public health services by NHS England, CCGs or local authorities.

Members and employees of a relevant NHS body or relevant health service provider have a duty to attend before a local authority when required by it (provided reasonable notice has been given) to answer questions the local authority believes are necessary to carry out its health scrutiny functions. This duty now applies to all those bodies listed above.

11 The type of information requested and provided will depend on the subject under scrutiny. It may include:

- Financial information about the operation of a trust or CCG, for example budget allocations for the care of certain groups of patients or certain conditions, or capital allocations for infrastructure projects, such as community facilities;
- Management information such as commissioning plans for a particular type of service;
- Operational information such as information about performance against targets or quality standards, waiting times;
- Patient information such as patient flows, patient satisfaction surveys, numbers and types of complaints and action taken to address them;
- Any other information relating to the topic of a health scrutiny review which can reasonably be requested.

Conflicts of Interest

12 The guidance includes the following provisions on conflicts of interest, which are reproduced in full:

‘3.1.24 Councils should take steps to avoid any conflict of interest arising from councillors’ involvement in the bodies or decisions that they are scrutinising. A conflict might arise where, for example, a councillor who was a full voting member of a health and wellbeing board was also a member of the same council’s health scrutiny committee or of a joint health scrutiny committee that might be scrutinising matters pertaining to the work of the health and wellbeing board.

3.1.25 Conflicts of interest may also arise if councillors carrying out health scrutiny are, for example:
• An employee of an NHS body.
• A member or non-executive director of an NHS body.
• An executive member of another local authority.
• An employee or board member of an organisation commissioned by an NHS body or local authority to provide services.

3.1.26 These councillors are not excluded from membership of overview and scrutiny committees, and, clearly, where the full council has retained the health scrutiny function, they will be involved in health scrutiny. However they will need to follow the rules and requirements governing the existence of interests in matters considered at meetings. Where such a risk is identified, they should consult their monitoring officer for advice on their involvement.'

Consultation on substantial reconfiguration proposals

13 Relevant NHS bodies and health service providers are required to consult a local authority about any proposal which they have "under consideration" for a substantial development of or variation in the provision of health services in the local authority's area. With increasing integration of health and social care, many proposals may be joint NHS-local authority proposals, with the involvement of the Health and Wellbeing Board at an early stage; health scrutiny should be party to such discussions.

14 As before, 'substantial development' and 'substantial variation' are not defined in the legislation. Joint protocols are recommended between the commissioners and health scrutiny committees. There has previously been some discussion in the South West about the benefits of agreeing a joint protocol for this purpose. Wiltshire decided to continue with a more flexible approach relying on good communication between all bodies on a case by case basis. This seems to have worked successfully to date but the publication of the guidance provides the opportunity to revisit the matter should the Committee so wish. Commissioners, not providers, are responsible for undertaking consultation. Where providers have a development under consideration, they will need to inform the commissioners at an early stage.

15 Commissioners must advise the health scrutiny function of the date by which it requires comments on the health consultation and the date on which they intend to make a decision whether to proceed with the proposal.

16 The health scrutiny function may make comments on any consultation proposal, and these comments may include a recommendation. Where a recommendation is included and the commissioner disagrees with that

recommendation, the commissioner must notify the health scrutiny function of the disagreement. Steps must be taken to resolve the disagreement.

17 Referrals to the Secretary of State may be made largely on the similar grounds as previously, which are:

- It is not satisfied with the adequacy of content of the consultation.
- It is not satisfied that sufficient time has been allowed for consultation.
- It considers that the proposal would not be in the interests of the health service in its area.
- It has not been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

18 Every effort must be made to resolve any disagreement between the Health Scrutiny Committee and the commissioners. Only commissioners, such as NHS England and CCGs, may be subject to referral. Where referrals are made to the Secretary of State for Health, they must be supported by evidence.

Recommendations

19 To acknowledge publication of the long-awaited Local Authority Health Scrutiny Guidance.

20 The Committee may wish to invite the CCG to consider developing a joint protocol on how they will reach a view as to whether or not a proposal constitutes a ‘substantial development’ or ‘substantial variation’ including best practice by others. Alternatively the Committee may favour a continuation of the current arrangements (Paragraphs 14 of the report and 4.2.2 of the guidance).

21 To note that the Council already has a mechanism to respond to consultations from relevant NHS bodies and health service providers on substantial reconfiguration proposals by delegating responsibility to the Select Committee (Paragraphs 8 of the report and 3.1.8 of the guidance)

22 To recognise the Select Committee’s responsibilities to respond to referrals made to it by Healthwatch or contractors under Regulation 21. (Paragraphs 9 of the report and 3.1.8 and 3.3.3 of the guidance)

23 To forward the report to the Health and Wellbeing Board, the CCG and Healthwatch for acknowledgement of the joint responsibilities that exist within the guidance and the need for effective communication with the statutory health scrutiny function in the best interests of credible and transparent governance of Wiltshire’s health services.

Paul Kelly, Scrutiny Manager (and Designated Scrutiny Officer)

Report author: Maggie McDonald, Senior Scrutiny Officer

Appendices

Appendix 1
Local Authority Health Scrutiny Guidance - Key Messages

Appendix 1

Local Authority Health Scrutiny – Guidance

Key Messages

- The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe. The new legislation extends the scope of health scrutiny and increases the flexibility of local authorities in deciding how to exercise their scrutiny function.

- Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working – relevant to this might be how well health and wellbeing boards are carrying out their duty to promote integration - and in making recommendations about how it could be improved.

- At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service ("relevant NHS bodies and relevant health service providers"1) and in testing this information by drawing on different sources of intelligence.

- Health scrutiny is part of the accountability of the whole system and needs the involvement of all parts of the system. Engagement of relevant NHS bodies and relevant health service providers with health scrutiny is a continuous process. It should start early with a common understanding of local health needs and the shape of services across the whole health and care system.

- Effective health scrutiny requires clarity at a local level about respective roles between the health scrutiny function, the NHS, the local authority, health and wellbeing boards and local Healthwatch.

- In the light of the Francis Report, local authorities will need to satisfy themselves that they keep open effective channels by which the public can communicate concerns about the quality of NHS and public health services to health scrutiny bodies. Although health scrutiny functions are not there to deal with individual complaints, they can use information to get an impression of services overall and to question commissioners and providers about patterns and trends.

- Furthermore in the light of the Francis Report, health scrutiny will need to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local Healthwatch.

- Health scrutiny should be outcome focused, looking at cross-cutting issues, including general health improvement, wellbeing and how well health inequalities are being addressed, as well as specific treatment services.

- Where there are concerns about proposals for substantial developments or variation in health services (or reconfiguration as it is also known) local authorities and the local NHS should work together to attempt to resolve these locally if at all possible. If external support is needed, informal help is freely available from the Independent Reconfiguration Panel (IRP)2 and/or the Centre for Public Scrutiny3. If the decision is ultimately taken to formally refer the local NHS's reconfiguration proposals to the Secretary of State for Health, then this referral must be accompanied by an explanation of all steps taken locally to try to reach agreement in relation to those proposals.

- In considering substantial reconfiguration proposals health scrutiny needs to recognise the resource envelope within which the NHS operates and should therefore take into account the effect of the proposals on sustainability of services, as well as on their quality and safety.

- Local authorities should ensure that regardless of any arrangements adopted for carrying out health scrutiny functions, the functions are discharged in a transparent manner that will boost the confidence of local people in health scrutiny. Health scrutiny should be held in an open forum and local people should be allowed to attend and use any communication methods such as filming and tweeting to report the proceedings. This will be in line with the new transparency measure in the Local Audit and Accountability Act 2014 and will allow local people, particularly those who are not present at scrutiny hearing-meetings, to have the opportunity to see or hear the proceedings.

Task Group Updates – 23 September 2014

Continence Services Task Group: There has been a response from the Executive and a meeting is being set up with the CCG to take forward the recommendations which they (the CCG) supported.

Help to Live at Home: An inaugural meeting is scheduled for the 3rd October to consider any actions as a result of the peer review; as well as the recent CQC report on Mears, a domiciliary care agency. The CQC report is considered as a substantive item on this agenda.

Review of AWP/Dementia Services: The Final Report is considered as a substantive item on this agenda and is also being presented to the CCG governing body on the afternoon on 23 September. The Committee is asked to endorse the recommendation that after a period of 2 years, the Task Group should re-form to review progress to ensure that, at a minimum, the actions identified in the commissioning Action Plan 2014-15 have been delivered.

Transfer to Care Task Group: The Task Group last met on 10 July with a further meeting scheduled for 29 October to receive updates on the Systems Thinking Review from John Rogers (Head of Systems Thinking) and the Commissioners.

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Overview and Scrutiny Work Plan

Committee	Review / Task Group	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Scrutiny Officer	STATUS (incl. date)
		Cabinet 18th Mar	Cabinet 22nd April	Cabinet 20th May	Cabinet 17th Jun	Cabinet 22nd Jul		Cabinet 16nd Sep	Cabinet 7th Oct	Cabinet 11th Nov		
				Council 13th May		Council 29th Jul			Council 21st Oct			

Overview and Scrutiny Work Plan

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		Cabinet 18th Mar	Cabinet 22nd April	Cabinet 20th May	Cabinet 17th Jun	Cabinet 22nd Jul		Cabinet 16nd Sep	Cabinet 7th Oct	Cabinet 11th Nov		
HEALTH	Tranfers to Care Task Group	Review in progress									ED	Task Group reviewing impact of measures to reduce DtoC figures. Next meeting Oct 2014.
	Continence Services Task Group	Review in progress		Health May 2014							MM	Following up recommendations with CCG.
	Review of AWP/Dementia Services	Review in progress						Health Sept 2014			MM	Final Report to HSC and CCG 23/09
	Help to Live at Home										MM	Inaugural meeting on 3 October to consider Peer Reviewon HTLAH and Mears CQC Report.
	Local Safeguarding Adults Board Annual Report							Health Sept 2014			MM	Annual Report to Committee Sept 14
	Public Health Annual Report							Health Sept 2014			MM	Annual Report to Committee Sept 2014