Wiltshire Safeguarding Adults Board

Annual Report

2012 – 2013

Contents

Foreword

I am pleased to present the Annual Report of the Wiltshire Safeguarding Adults Board (WSAB) for 2012-13.

My theme last year was "development in a time of change". Change has certainly continued to be part of the context of the WSAB, and as the year under review ended we welcomed new organisations to the WSAB: The NHS England area team[1] and the Clinical Commissioning Group which replaces the Primary Care Trust cluster. Changes have also come through the creation of a more devolved structure at the Avon and Wiltshire Partnership NHS Trust, from changes of personnel at some partner organisations and from the Fire Service agreeing to join the Board.

What has particularly struck me in reviewing last year's work has been that we have made progress across the range of our responsibilities, from direct engagement with service users through to ensuring our own work is well-structured and effective. We have responded both to national change and to local needs, and this has been achieved in the context of continuing heavy financial pressures on all partner agencies and complex organisational change for many.

More detail can be found in the rest of the report but some highlights were:

- A successful workshop with nearly fifty service users to brief them about the role of the WSAB and to find out how they want to have their voices strongly and consistently heard in the Board's work and in safeguarding activity more generally. This is leading, in the first instance, to setting up a reference group of service users to inform the Board's work, with the potential to contribute in future to other aspects of safeguarding work.
- Responding to national developments, in particular the various reports arising from the events at Winterbourne View Hospital. All partners contributed to establishing a strong action plan which has been integrated into our Business Plan for this year.
- Making significant improvements, through the work of the Quality Assurance sub-group, to the reports the Board receives about performance management and the quality of services. This work will continue in the current year.
- Work has started on developing a communications strategy jointly with the Children's Safeguarding Board, but there is much more to do on this. The WSAB has, we hope, raised its own visibility by adopting the logo that is on the front of this report.

Looking ahead, our Business Plan for the current year and beyond builds on the last year's work and is ambitious for the future of safeguarding despite the pressures on all organisations. Our activities will include:

- Ensuring that the learning about safeguarding from the Winterbourne View Hospital serious case review and related reports, and from the Mid-Staffordshire Inquiry is comprehensively applied in Wiltshire.

[1] The team covers Gloucestershire, Swindon, Wiltshire and Bath & North East Somerset local authority areas.

- Develop the Service User reference group's role and impact, and pursuing parallel work to involve informal carers more fully in the work of the Board.
- Taking forward the communications strategy and related work
- Continue to develop our Quality Assurance system so that we can be confident that good performance is recognised and problems are identified and addressed.
- Respond to the requirements of the Care Bill when it becomes law including ensuring that our policies, procedures and training are all up to date to support staff in their complex work.

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 continuing to work with the Board through this year to ensure that the many changes in and pressures on services do not reduce the wellbeing and protection of all adults in Wiltshire.

Independent Chair, Wiltshire Safeguarding Adults Board

September 2013

1. Background

1.1. All persons have the right to live their lives free from violence or other sorts of abuse, but in the 1980's and 90's a number of serious incidents came to light in which vulnerable adults had not received the protection and support they needed and had been subject to abuse. As a result, in 2000 the government published "No Secrets"[2] which 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 robustly with any incidents that did occur. 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. A vulnerable adult was defined 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]

1.3. Most recent thinking is that it is preferable to refer to "adults at risk". This reflects 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".

1.4. The Care Bill 2013 adopts the "adults at risk" terminology and brings forward, as part of wider legislation to create a single modern legal framework for adult care and support, proposals to put Safeguarding Adults Boards onto a statutory footing. This has been a long-awaited development and is widely welcomed by all involved in ensuring that all adults are able to live safely as citizens in their community. Section 6 below refers to this and other recent policy developments in a little more detail.

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 in the Business Plan 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 necessary:

- Policy and Procedures (joint with Swindon SAB)

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

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

- Quality Assurance
- Learning and Development
- Serious Case Review (ad hoc)

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

2.2. There have been several changes to the Safeguarding Board's membership at the end of the year under review, as the new NHS structures came into place, and some new appointments took over in other organisations. The Terms of Reference show that updated membership and the Board will be using its development session in September 2013 to take stock of its own current capability as a team.

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 2012-13 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 in 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 WSAB has been accountable through the Corporate Director to the Cabinet Wiltshire Council. However, the establishment of the Health and Wellbeing Board, under the Health and Social Care Act 2012, now makes this the appropriate reporting line for the Board. The Annual Report for 2011-12 was presented to the Board in its shadow form, and this arrangement will continue now that it is in substantive role. Further work will be needed on how the WSAB and the Health and Wellbeing Board will work together on issues related to safeguarding.

2.7. The Board does not currently have an established budget or an agreement about how the costs of its work will be shared among the partners. Discussions to move this forward have started in the new business year.

3. Summary of Activity during the Past Year

3.1. The Board priorities for 2012-13 were set out in last year's Annual Report, and reflected the overall priorities of the WSAB and some key priorities of its partner organisations. This section focuses on achievements against the WSAB priorities, and any additional activity that had to be undertaken during the year. Individual partners' comments on their own progress can be found in section 5 below.

3.2. Compared to the previous year, progress during 2012-13 has been steadier, which has been in part because key people have been more consistently available. However, the arrival of the part-time Business Support Officer to the WSAB has had a major positive impact on the organisation of the Board's work and therefore its progress. She provides support both to the main Board and to the sub-groups and task groups, ensuring meeting arrangements are well-organised, providing notes promptly, progress-chasing and generally enabling a much more focussed approach to the WSAB's work. Sub-group and task group work is still sometimes affected by attendance problems.

3.3. The Board has fulfilled its commitment to take local action in response to the reports arising from the abuse at **Winterbourne View Hospital.** The September meeting set up a task and finish group led by the Independent Chair to review the large number of recommendations arising from the Serious Case Review[4] and related reports, and propose a local action plan. An initial draft, pending the publication of the Department of Health final report[5] was considered at the December meeting, revised to take account of the DH report and, following consultation in individual organisations, was adopted in its final form at the June 2013 meeting. The agreed actions have now been integrated into the Board's main Business Plan.

3.4. The development of the **Care and Support Bill** was monitored through the year, but it did not reach a point where any action was required by the Board. Now renamed the **Care Bill**, it has started its progress through parliament and responding to its enactment is included in the 2013-15 Business Plan.

3.5. Substantial progress has been made to **establish a quality assurance and performance management system** for the Board. The Quality Assurance sub-group has used a model developed in the South West region as the basis for creating more structured quarterly reports to the Board that cover a wider range of information. Further detail about this can be found in section 4 below. This is work in progress and will continue to be developed, and will need to adapt to changing situations as they arise.

3.6. The WSAB Chair and Business Support Officer have been working with Wiltshire and Swindon Users Network to develop a **more structured and comprehensive**

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[4] *Winterbourne View Hospital, A Serious Case Review*; Margaret Flynn for South Gloucestershire Safeguarding Adults Board, July 2012

[5] *Transforming Care: A National Response to Winterbourne View Hospital*; Department of Health, December 2012

approach to the involvement of service users in the work of the Board and safeguarding system. This is needed in three different ways:

- Feedback from the experiences of service users who have been at the centre of an investigation
- An effective and sustainable voice in the work of the Board
- Involvement in the development of policy, procedures and training

3.7. An initial open workshop session was held in November with the aim of giving service users some information about the role of the WSAB, finding out their views about safeguarding and related services and how service users can have a strong voice in the Board's work and in safeguarding activity more generally. Forty seven service users from a wide range of backgrounds attended the workshop, which was generally very positively received. There was lively discussion and extensive comment which was fed back to the WSAB and work is now progressing to set up a reference group. This is planned to meet quarterly between the meetings of the Board to give views on forthcoming agenda items, get feedback on items discussed at the previous Board meeting and identify key issues that service users think need to be addressed.

3.8. Separate work is being done to ensure that service users are fully involved in discussions about investigations of alleged abuse, either directly or through an advocate where necessary. This will include hearing the outcomes they want from the investigation and identifying at the end of the process whether these have been achieved.

3.9. Work on the **involvement of informal carers** in the work of the Board and safeguarding system has progressed only slowly after initial discussions were held with Wiltshire Carers. This has been mainly because of their changes of personnel and changing workload pressures. However, it is hoped that an introductory workshop similar to that with service users will be arranged soon.

3.10. The development of a **communications strategy** jointly with the Children's Safeguarding Board is in its early stages. The intention is to support awareness raising and good information sharing across all Wiltshire's communities and to update web-based information to support this. It has recently been identified that this can be linked to related work being done by the Community Safety Partnership.

3.11. The **smooth transition of safeguarding work** from the PCT to the Clinical Commissioning Group (CCG) has been assisted by some continuity of staff. The Board will continue to monitor this as the new NHS structure settles down. The area team of NHS England (Bath, Gloucestershire, Swindon and Wiltshire), which has responsibility for supporting and providing assurance on safeguarding across all NHS bodies in its area, is now represented on the Board alongside the Clinical Commissioning Group and the provider trusts. The CCG has provided a note of the relative responsibilities of the CCG and NHS England which can be found at Appendix 6

3.12. In addition to these priority activities the Board has, through its Policy and Procedures sub-group, updated the joint policies and procedures it shares with Swindon Safeguarding Adults Board. Although further work will be needed once the Care Bill is enacted and associated regulations issued, this updating was essential to reflect changes in guidance, terminology and partner organisations since the last revision in 2006.

3.13. The Board as a whole has continued to deliver its training strategy, and this is reported in section 4 below. Individual partner reports confirm their own training work through the year.

3.14. During the year the first Police and Crime Commissioners were elected and took up their new roles. The Chairs of the Children and Adults Safeguarding Boards for Swindon and Wiltshire had an initial meeting the Commissioner in January 2013 and these are intended to continue at six monthly intervals. The Commissioner has to produce a Police and Crime Plan, and that for Wiltshire and Swindon has "Protecting the most vulnerable in society" as one of its six priority areas.

4. Monitoring and Quality Assurance Activity

General performance reporting

4.1. 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:

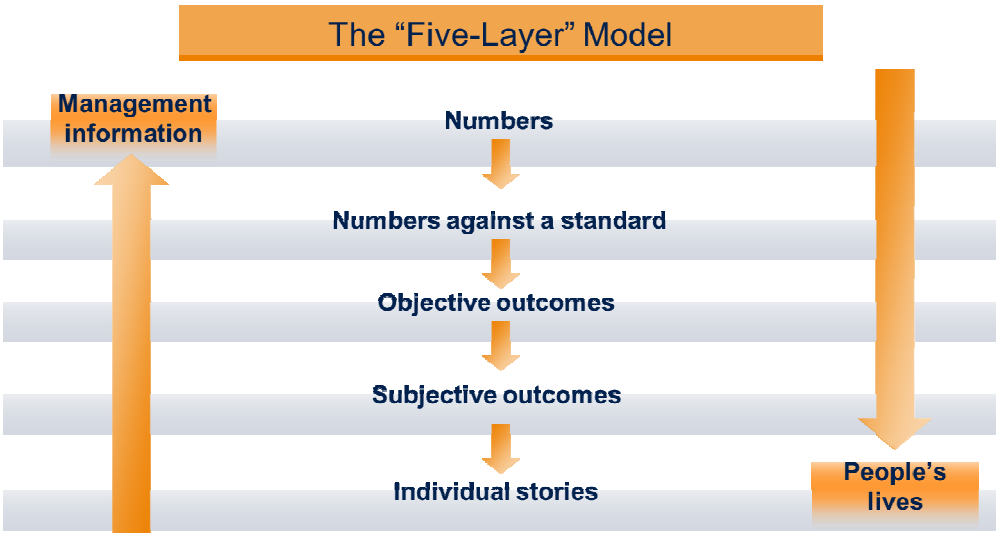
- The number of alerts received in the past year has increased by 97%. There have been similar increases across the South West, but Wiltshire saw the second highest rise across the region, with only North Somerset having a higher percentage increase. While the general increase may relate to increased public awareness of safeguarding, there are two likely influences on the exceptional increase in Wiltshire. Firstly, the impact of the change in the recording system, so that since May 2012 all alerts have been triaged via SAMCAT which creates a much more comprehensive record; secondly the recording of large scale investigations has improved and all residents in a home subject to such an investigation are counted, whether or not there has been a specific allegation relating to them. The Board will continue to monitor this pattern and the reasons for it.
- This increase in alerts has been reflected in an increased number reaching the threshold for investigation. However, we need to check how this compares in percentage terms as well.
- There has been a significant increase in the number of alerts coming from residential care staff and CQC staff (Appendix 3, figure 4). Again, the reasons for this need to be explored and the pattern monitored, but it is likely that at least some of the increase is due to increased awareness of safeguarding in

those staff groups and the action that needs to be taken when concerns are identified.

- As would be anticipated with the demography of Wiltshire, the overwhelming majority of alerts relate to White British people. (Appendix 3, figure 6). There may, however, be a need for further work in raising awareness in other ethnic communities.
- There have been increases in alerts for all customer groups (Appendix 3, figure 7), apart from those with mental health needs. Over the past three years the number of alerts involving people with learning disabilities has trebled, which is likely to indicate raised awareness following the events at Winterbourne View Hospital.
- There has been an increase in the percentage of investigations where the allegations of abuse were substantiated, from 40% in 2011/12 to 58% in 2012/13. (Appendix 3, Table 3).

4.2. As reported in 3.6 above, substantial progress has been made to establish a quality assurance and performance management system for the Board, using a model developed in the South West region. The model is shown in Figure 1 below.

Figure 1



4.3. The idea is that different types of information are used to ensure that the Board gets a balanced view of the service, both from the perspective of the organisation and the person who receives the service. Starting from the top, layer 1 deals with basic service inputs and outputs – what work came in and what was done with it. Layer 2 goes a bit deeper, looking at why people needed a service and the different ways that the service was provided.

4.4. Layers 3 and 4 try to identify what the impact was both from the organisation's perspective (what we think happened as a result of the activity) and very importantly from the service user's perspective. We are working on improving and extending the ways that service users can tell us what their experience was and whether the service improved their situation in the way they wanted. Layer 5 expands on all of the other layers by looking in more detail at some specific cases,

whether about individuals or institutions, and should help maintain the link between the WSAB's work and the front line.

Audit findings

4.5. In November 2012, South West Audit Partnership undertook a limited audit of some care records in Wiltshire Council. They audited 6 case records of people who had been through the safeguarding process in operational teams and two large scale investigations in SAMCAT. Their key findings about the six individual case records included:

- Three met all of the standards being used.
- In the other three records:
    - CareFirst did not always contain a complete record of the case and related history
    - The CareFirst record was not always completed fully and accurately.
    - SAMCAT triage advice was not followed
- Reference to the quality of some records of safeguarding meetings.
- Criticism of the monitoring system being used to track whether timescales were being met.

The Council has now completed and is implementing an action plan in relation to the findings.

Large Scale Investigations

4.6. By the nature of large scale investigations, all involved a number of residents and a number of issues. These investigations are resource intensive and are managed by the Safeguarding Adults and Mental Capacity Act Team rather than the operational teams. Key themes to emerge from large scale investigations over the past 12 months have been:

- Poor care planning
- Medication Management
- Incident Reporting
- Mental Capacity Act/Dols
- Poor leadership
- Lack of management

4.7. Two case studies at Appendix 5 illustrate the issues that arise in these kinds of cases

Risk register

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

Monitoring regulated services

4.9. Wiltshire council, NHS Wiltshire and CQC have worked closely, meeting on a bi monthly basis to discuss inspection and review findings of regulated services and triangulate this information received from reviews, safeguarding alerts and

complaints to the council and serious untoward incident reporting and complaints to NHS Wiltshire and whistle-blowing to each agency. The meetings have proved useful and helped the early identification of concerns to help prevent abuse from occurring or potentially escalating.

Training programme

4.10. Training continues to be an important part of ensuring quality services. The full programme of training organised on the Board's behalf by Wiltshire Council is based on the National Capability Framework[6], which identifies the capabilities required by all the different professional groups who have responsibilities for safeguarding adults at risk of harm. These are identified in broad groups A to D and range across:

- general staff who need basic understanding of the issues
- key front line professionals for whom safeguarding is a major part of their role
- Strategic managers and leaders up to Chief Executives and including safeguarding board chairs and members

4.11. The chart below give a breakdown of figures for safeguarding adults staff training within the year which identifies how elements of the programme relate to the groups in the national framework and meets the requirements for common induction standards and multi-agency procedures roles.

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	3 programmes	60
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		786
Staff group A (NCF) – responsibility to contribute to safeguarding adults	Direct care staff in registered/regulated services – independent sector	11 courses	275

[6] *National Capability Framework for Safeguarding Adults;* Learn to Care and Bournemouth University 2012

Staff group A (NCF) – responsibility to contribute to safeguarding adults	Direct care staff in registered/regulated services - council	9 courses	162
Staff group B (NCF) – Considerable professional & organisational responsibility for safeguarding adults	Managers and senior workers in registered/regulated services – independent sector & council	5 courses	100
1 day course to get Investigating Officers up and running in the role	New Investigating Officers	3 courses	35
3 day course covering adult protection legislation, procedures and processes including Achieving Best Evidence and report writing	Investigating Officers	3 courses	33
Half day update & CPD session	Experienced Investigating Officers	2 workshops	28
1 day course to develop knowledge and skills in the Investigating Manager role	New Investigating Managers	1 course	25
Half day update & CPD session	Investigating Managers (also attended by Police, NHS & advocacy service)	4 workshops	80
WSAB Development Half day session - Review of developments in the past year; creating a quality assurance framework; user and carer involvement; priorities, targets and timescales – Business plan 2012 - 15	WSAB members	1 session	14

4.12. The Learning and Development Team's key plans for the current year are:

- Build capacity in registered services by providing Train the Trainers courses for managers/senior staff plus ongoing support and standardisation

- Continue to provide courses for staff group B and reduce the number of courses for staff group A (see chart above) as in-house trainers in services will meet their own training needs at that level.
- Review effectiveness of training and support for Investigating Officers, including participation in a research project on training transfer with Plymouth University

4.13. The Learning and Development sub-group's priorities for the current year include making sure that learning is really embedded in practice, and it will be drawing on research by Research in Practice for Adults (RIPFA) to support this work. The sub-group has started joint meetings with Swindon SAB Learning and Development sub group twice a year, and these will continue.

Advocacy Service

4.14. The use of an advocacy service is an important element of monitoring and quality assurance as it provides independent people to ensure that the service user's voice is heard in safeguarding work and provide feedback to agencies as appropriate.

4.15. Swan Advocacy provides statutory advocacy services in the county. In addition to a generic advocacy service with a strong focus on safeguarding the rights of service users, Swan also provides independent mental health advocates and independent mental capacity advocates who ensure that those without capacity are involved in decision making and their best interests and human rights are protected. It aims are:

- To ensure that the client's voice is heard
- To empower clients to make effective life choices
- To encourage self advocacy

4.16. Swan provides an independent service for vulnerable adults that is free and confidential.

- The service is impartial and client-centred regardless of disability, colour, ethnicity, gender or sexual orientation
- Advocates help clients to communicate their needs, wants and feelings
- Swan will contest arbitrary decisions and question bureaucracy
- Keeps the client at the centre of any decisions made on their behalf
- Advocates speak up for vulnerable people and also help them to speak for themselves

4.17. 2012-13 has seen a continued growth in the use of the service with 998 new referrals in this period across the whole range of the service's work.

5. Partner Reports

5.1. Wiltshire Council

Structure and approach to safeguarding

Maggie Rae, Corporate Director is the Safeguarding Lead for Adults. On a day to day basis the Service Director for Adult Care and Housing and the Head of Specialist Commissioning and Safeguarding Adults take the lead. There is also a lead Member for Safeguarding who is a member of the Wiltshire Safeguarding Adults Board. Wiltshire Council see the Safeguarding of vulnerable adults and children as one of its core functions. Currently Wiltshire Council is the sole funder for the Safeguarding Adults Board and its sub groups.

Wiltshire Council also wants to ensure that there are key links between Adults and Children's Safeguarding. The Service Director, Adult Care and Housing is a member of both Boards. The Head of Specialist Commissioning & Safeguarding Adults is a member of several sub groups of both Boards. The Chairs of the Safeguarding Adults Board, Safeguarding Children's Board, Children and Young Peoples Trust Board and Community Safety Partnership meet on a 6 monthly basis.

Over the past year Wiltshire Council has increased investment in Safeguarding Adults. The specialist Safeguarding Adults and Mental Capacity Act Team (SAMCAT), now have a team manager, 2 Professional Leads, 4 Senior Social Workers, 4 minute takers a DoLS Co-ordinator and a Business Support Officer. This emphasises Wiltshire Council's commitment to safeguarding the citizens of Wiltshire. Even when cuts have to be made in many areas of public service, there is increasing investment in Safeguarding.

The triage function has continued to work effectively to ensure that the right response is made to all alerts. Any referrals which are particularly sensitive or complex, and all large scale investigations and whole home investigations are managed by SAMCAT. The remainder of referrals are managed in locality teams with the support of SAMCAT. The system ensures that patterns of abuse are picked up at an early stage.

Achievements in 2012-13

The following have been notable achievements during this year:

- Since the introduction of the triage system there has been an increase of approximately 700 referrals from the previous year. However there has not been a huge increase in referrals that have led to investigations. This indicates that the threshold guidance is having an impact.
- SAMCAT have also seen a very large increase in large scale and whole home investigations. This has risen from 5 in 2011/12 to 21 in 2012/13.
- The commissioning of an audit of the Council's Adult Safeguarding work, the results of which have now led to an action plan and focus for some internal work.
- Establishment of a system of case file audit and quality assurance in relation to Safeguarding Adults.
- Performance monitoring activity is shared throughout Adult Care Operations and Commissioning on a weekly basis.

- CQC reports are scrutinised and key findings fed back to Adult Care Operations and Commissioning on a weekly basis.
- Wiltshire Council meets with CQC on a bi-monthly basis to share knowledge and intelligence over areas of concern in order to ensure there is intervention at as early a stage as is possible and appropriate.
- Workshops for Investigating Officers and Managers are held on a quarterly basis and led by SAMCAT.

Safeguarding Adults staff training within the year

Staff in Wiltshire Council undertook a wide range of training in relation to safeguarding adults.

- 60 new social care workers covered Common Induction Standard 6 - Principles of safeguarding in health and social care during the social care induction programme they attended
- 200 council staff completed an e learning module on safeguarding adults awareness
- 162 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)
- managers and senior staff in council services regulated by CQC completed training in line with Group B requirements of the NCF
- 25 staff (mainly social workers and some occupational therapists) completed the 4 day Investigating Officer training, including mental health social workers; formerly managed by AWP and now managed directly in the council
- 25 managers, deputies and level 4 social workers completed one day of training in the role of the Investigating Manager

This training was organised and run by the Adult Social Care L&D Team, now part of HR & OD within the council (since Summer 2013).

Regular half day updates and CPD sessions were held by members of SAMCAT for both Investigating Officers (2 sessions) and Investigating Managers (4 sessions). These were well attended.

Key plans and objectives for safeguarding adults in the coming year

- Preparation for Peer Review which is taking place in November.
- Improve the quality of conference management by:
    - Introduction of templates for minute taking
    - Provide training for minute takers.
    - Introduce set agendas for all conferences
    - Provide training for Conference Chairs within the Investigating Manager Workshops.
- Learn from key messages coming from quality audits and give regular feedback to staff and improve practice.
- Learn from the Children's Safeguarding MASH team in order to discuss with key partners whether this model could be extended to Adults.

- Update information about Adult Safeguarding on Council website.
- Improve the tracking of alerts by devising a system which will do this and report results to WSAB.
- Be part of the regional work which is taking place in relation to Safeguarding Adults.
- Implement a new system of quality assurance within Commissioning ensuring this links and works closely with Safeguarding Adults.
- Along with partners, implement key recommendations of the Department of Health recommendations arising from Winterbourne View.
- Further raise awareness with Council Members by participating in Members' Induction programme.

5.2. Avon and Wiltshire Partnership Mental Health Trust

This was a year of significant change and development in the roles undertaken by AWP to safeguard adults throughout 2012/13.

Achievements in 2012-13

AWP continued to play an active role in the Safeguarding Adults Board and its work. AWP attended the Board on a regular basis and has chaired the group that has completed the review the Wiltshire and Swindon Safeguarding Adults at Risk Policy and Procedures. AWP also has a variety of staff involved in all the Board's sub groups.

In May 2012, as part of the separation of health and social care services in mental health within Wiltshire, AWP ceased to undertake management of safeguarding adult alerts on behalf of Wiltshire Council, moving to an alerter role, in line with other providers following this challenging period of change.

The Trust has continued to seek to improve its delivery of safeguarding in practice, with revision of the policy and guidance to practitioners, better access to information for staff on the intranet and service users and the public on the Trust Website, and significant updates to the training of practitioners.

AWP has also reviewed its services in light of the Winterbourne View Hospital reviews and developed an action plan against the relevant recommendations. It also considered actions arising out of the recommendations from the Francis Report on Mid-Staffordshire.

The Trust has maintained compliance with Outcome 7 (Safeguarding) of the CQC Essential Standards in all CQC inspections of teams in Wiltshire during 2012/2013.

The Trust has continued to ensure that its staff is trained in their role to safeguard adults, with the target of 80% of staff being trained on a 2 year cycle at Alerter level (level 2) being maintained during 2012/2013.

Key plans and objectives for safeguarding adults in the coming year

AWP will be looking to use the current changes in its organisational structure to improve the direct relationship between its local services and the safeguarding adult

partnership and Board in 2013/2014, and will be taking forward a number of key actions, including:

- Developing systems capturing risks and concerns, to assist triangulation and identify risks, and themes.
- To implement the Winterbourne View and Francis report action plans
- Demonstrate compliance with the safeguarding adult requirements set out in the new NHS contract for 2013/2014
- Develop joint understanding of application of clinical management and safeguarding thresholds with key partners in differing mental health inpatient
- The roll out and implementation of the changes within the revised multi agency safeguarding procedures, particularly in relation to the active involvement of the person in their own safeguarding.

5.3. NHS Wiltshire

Structure and approach

This is the final report for NHS Wiltshire Primary Care Trust and covers a period of substantial change and transition.

The Primary Care Trust ceased to exist on the 31st March 2013 and responsibility for commissioning healthcare transferred to Wiltshire Clinical Commissioning Group (CCG). The CCG operated in shadow mode for the latter half of the year and the focus for the PCT has been to ensure continuity of service and to support the CCG to achieve NHS England Commissioning Board authorisation.

The Cluster arrangement with NHS B&NES continued through the year with the Safeguarding Leads in B&NES and Wiltshire providing cover for annual leave and support when necessary.

NHS Wiltshire Executive Lead for Safeguarding and representative on the Wiltshire Safeguarding Adults Board was The Director of Nursing and Patient Safety. The Adult Safeguarding and Mental Capacity Act Lead deputised for the Director in her absence and represented NHS Wiltshire on the LSAB Quality and Performance, Training and Policy subgroups.

Activities during 2012-13

Quality Assurance was maintained by:

- Safeguarding Adults was a standing agenda item on the Clinical Governance and Quality Committee. Quarterly reports to this committee detailed updates on providers of concern, anonymised updates on safeguarding investigations involving health funded service users and identified emerging concerns.
- The use of Quality Assurance visits during the year, one of which was a specific safeguarding visit. These are a mix of announced and unannounced visits with a focus on a number of key quality and patient safety issues, including adult safeguarding.
- Safeguarding Adults activity is an agenda item at each quarterly Clinical Outcomes and Quality Assurance meeting with providers.

- Provider concerns were raised at the quarterly meetings and safeguarding issues requiring a more urgent response were addressed at an executive level through the Director of Nursing or the Adult Safeguarding Lead.

All **Serious Incidents Requiring Investigation** (SIRI) reporting grade 3 and 4 pressure ulcers are reviewed by the Adult Safeguarding Lead. The reviews highlighted a lack of safeguarding scrutiny during the investigation process. These concerns have been raised with the providers and we continue to work with providers to embed safeguarding in the investigation process.

NHS Wiltshire's participation in the **Care Quality Monitoring Group** continued with representation from the Safeguarding Lead, Head of CHC and Head of Quality and Performance. The Membership of this group comprises the Care Quality Commission, NHS Wiltshire and local authority commissioners. The group's objectives are:

- To monitor and identify emerging risks to quality standards and pro-actively address these risks through a combined, coordinated response
- To identify any wider commissioning or strategic issues relating to the sustainability of the care provider sector and ensure these are referred to the relevant commissioning bodies.

It is anticipated that the Adult Safeguarding Schedule will be used for the 2013/14 **contracts.** This has been amended to incorporate the recommendations from various national reports and the ADASS self-assessment audit so that the quality framework has current Adult Safeguarding expectations in it. The CCG will have a statutory responsibility to ensure that providers of commissioned services have adequate safeguarding structures in place.

During 2012-13 NHS Wiltshire worked in partnership with Wiltshire Council's Safeguarding Adults and Mental Capacity Act Team (SAMCAT) on a number of **large scale investigations,** supporting these investigations through scrutiny of care records and offering advice relating to health concerns. NHS Wiltshire also supported **individual alerts** relating to healthcare issues.

NHS Wiltshire and Wiltshire Council have a joint action plan following a review of the recommendations arising from the reports on **Winterbourne View Hospital**.

In response to the report of the **Mid Staffordshire** the PCT has requested all providers to review the findings of the report and inform the PCT of subsequent actions within their organisation. The Francis Report has the potential to significantly change the effectiveness of commissioning for quality. CCGs have an opportunity to take a new approach to quality assurance and improvement and to develop different relationships with their local providers, in order to ensure that they are confident that fundamental standards of care are being met.

Our **complaints** procedures have been reviewed including outcomes on as near a real-time basis as possible. An anonymised summary of each upheld complaint relating to patient care, in terms agreed with the complainant, should be published on its website along with the trust's response. Where the patient or complainant refuses, or for some

other reason publication is not possible, the summary should be shared confidentially with the commissioner and the CQC.

In its capacity as a **Supervisory Body for MCA Deprivation of Liberty Safeguards** (2007) NHS Wiltshire received 61 requests for standard authorisations between April 2012 and March 2013; of these 24 were authorized (40%). Supervisory body responsibilities transferred to the local authority with effect from 1st April 2013. The CCG will remain responsible for ensuring that commissioned services are compliant with the Deprivation of Liberty Safeguards and for raising third party concerns where appropriate.

Training sessions were run In the West Wiltshire, Yatton Keynell and Devizes (WWYKD) area on Adult Safeguarding and Mental Capacity Act for General Practitioners and Practice Managers to support their CQC registration.

During this year there has been a concerted effort to support **CCG Authorisation**. The CCG Three year strategic Plan 2012-2015 encompasses the principles of adult safeguarding throughout the document and there is a clear governance structure including adult safeguarding as part of the Clinical Governance and Patient Safety Committee. The Adult Safeguarding Commissioning Policy has been developed and ratified. The policy incorporates key issues relating to national recommendations in terms of roles and responsibilities. The shadow CCG board (Clinical Commissioning Committee) received regular updates and reports relating to healthcare providers.

Key plans and objectives for safeguarding adults in the coming year

The protection of vulnerable adults is a core element of healthcare provision. The following are objectives stated in the three year strategic plan. Training sessions for commissioners will highlight the relevance of adult safeguarding to commissioning and roles and responsibilities in accordance with local and national policy and legislation.

- The CCG's governance framework will reflect a clear line of accountability for safeguarding as recommended in 'Arrangements to secure children's and adult safeguarding in the future NHS, the new accountability and assurance framework – interim advice'. NHS Commissioning Board 2012.
- The CCG will be an active partner in the Local Safeguarding Adults Board. Our governance framework will include systems to monitor the quality of provision and offer assurance that adult safeguarding concerns are identified and dealt with robustly.
- The CCG will work proactively with service providers to commission high quality and safe services for adults contractually under our care. The NHS contract incorporating safeguarding standards will be used for services commissioned by the CCG.
- The CCG will adopt a zero tolerance approach to adult abuse and will work to ensure that its policies and practices are consistent with agreed local multiagency procedures and compliant with the Mental Capacity Act 2005. In situations where there is a duty to intervene, that intervention will be proportionate to the level of risk.

5.4. Wiltshire Probation Trust

Structure and approach

The Director of Operations has responsibility for all safeguarding work and represents Wiltshire Probation Trust on the Wiltshire Safeguarding Adults Board. There are two middle managers who hold the operational responsibility to ensure that safeguarding policies and practice standards are cascaded to all staff in the organisation. Middle managers and practitioners are also represented on all the sub-groups to ensure that the Trust is kept up to date with all safeguarding research and initiatives.

Wiltshire Probation Trust is committed to providing effective and individualised support to all vulnerable adults who come in contact with the Trust. This includes service delivery both to offenders and their families as well as adult victims of crime. 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 offenders 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. This combination of support has been facilitated by the Trust working closely with both Multi-Agency Public Protection Arrangements (MAPPA) and partners from the LSAB. The Trust also has a responsibility in liaising with all victims of serious crime in cases where an offender received a prison sentence of at least 12 months. For those victims who are vulnerable adults, the Trust's Victim Liaison Officers may be the first agency that meet with them and can then direct these individuals towards appropriate advice and support.

We ensure that all staff who have contact with offenders attend the safeguarding training events and the training plan is annually reviewed to ensure that staff also attend refresher training. There is regular monitoring and auditing of cases which is undertaken by middle managers and safeguarding also forms part of the supervision process with offender managers.

The Trust has recently reviewed its representation and membership of Boards and sub-groups to ensure focused and appropriate representation and prioritisation of safeguarding work.

Key plans & objectives for safeguarding adults in the coming year

Wiltshire Probation Trust will continue to prioritise its safeguarding work in partnership with other agencies. In particular we will:

- Ensure that staff have access to sufficient training to enable them to maintain the necessary skills in working with vulnerable adults and their families.
- Continue to prioritise our work in domestic abuse in terms of the perpetrator domestic abuse programmes that we provide to offenders as part of a sentence of the court as well as to perpetrators that are referred to us from Cafcass.
- Continue to support the partners of domestic abuse perpetrators through the work of the Women's Safety Worker.
- Actively contribute to Domestic Homicide Reviews and subsequent action plans.

5.5. Wiltshire Police

Structure and approach

The Wiltshire Police Safeguarding Adult Investigation Team consists of specially trained investigators. The team comprises a Detective Sergeant, 7 investigators and an administrator. The strategic lead for Safeguarding Adults is the Detective Superintendent of the Public Protection Department, and he attends the Board. The Operational Lead for Safeguarding Adults attends the Quality Assurance sub-group.

Achievements during 2012-13

During 2012, Wiltshire Police introduced the 'Three Strands of Vulnerability'. The three strands relate to welfare, vulnerable people and safeguarding adults. The process map which was devised gave officers direction and guidance on what action they needed to take, dependent upon the circumstances they were dealing with. The benefit of this for the Safeguarding Adults Investigation Team is that they receive fewer referrals which do not need to be reviewed and can focus on the referrals which require their skills and knowledge to investigate. Since the introduction of the 'Three Strands' the number of referrals involving welfare concerns of vulnerable adults is reducing as officers are referring directly to Swindon Careline or Wiltshire customer advisors. We plan to reinforce the 'Three Strands' message within Wiltshire Police by carrying out regular briefings to neighbourhood policing teams, response officers and CID officers

Staff from the safeguarding team are also giving presentations to Nursing Homes to improve the reporting of abuse and to make sure that evidence of any abuse is properly recorded. Recently a presentation was given to a nursing home and as a result of the training given, we saw a marked increase in referrals from this nursing home as staff there understood fully what their responsibilities were regarding the reporting of vulnerable adult abuse

Wiltshire Police is currently reviewing the training package for training officers to tackle vulnerable adult abuse.

Financial abuse accounts for approximately 30 per cent of the referrals to the Safeguarding Adults Team. These cases are often complex in nature and involve dealing with fluctuating capacity, powers of attorney and applications for production orders. The Safeguarding Adults Department is now referring the majority of their financial abuse investigations to the Wiltshire Police Complex Fraud Unit. The Complex Fraud Team has excellent expertise to tackle complex fraud and securing the evidence in an effective and efficient manner. The safeguarding team will continue to manage the safeguarding aspect of the vulnerable adults in relation to financial abuse. The Safeguarding Team will also continue to manage the excellent working relationship we have with the Wiltshire Court of Protection team which is very proactive in its work to protect the finances of vulnerable adults. We currently have two major financial abuse cases which are with the Courts

Officers in the Public Protection Department are well into becoming omni-competent with regards to Safeguarding Adult cases. Officers from the Domestic Violence

Investigation Team have led a number of safeguarding adult investigations which have involved domestic abuse.

Key plans and objectives for safeguarding adults in the coming year

In line with the policy and procedures for Safeguarding Vulnerable Adults in Swindon and Wiltshire, Wiltshire Police will:

- actively work together within the agreed inter-agency framework based on the guidance contained in 'No Secrets' (2000 Department of Health, Home Office)
- actively work together within the agreed procedures, guidance and protocols underpinning this framework to investigate abuse and manage protection;
- actively promote the empowerment and well-being of vulnerable adults through the services we provide;
- actively support the rights of the individual to lead an independent life based on self determination and personal choice;
- recognise people who are unable to take their own decisions and/or protect themselves, their assets and their bodily integrity;
- recognise that the right to self determination can involve risk and ensure such risk is recognised and understood by all concerned, and minimised whenever possible;
- ensure the safety of vulnerable adults by integrating strategies, policies and services relevant to abuse within all systems and legislation created to safeguard adults
- ensure 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;
- ensure 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;
- identify others who may be at risk of harm, including children, and effect immediate referral to the appropriate authority;
- recognise the on-going duty of care to service users who perpetrate abuse and facilitate any necessary action to address abusive behaviour;
- actively promote an organisational culture within which all those who express concern will be treated seriously and will receive a positive response from management;
- 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.

The aim of all staff within the Safeguarding Adults Investigation Team within the Public Protection Department throughout this 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.
- 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.

5.6. Royal United Hospital, Bath

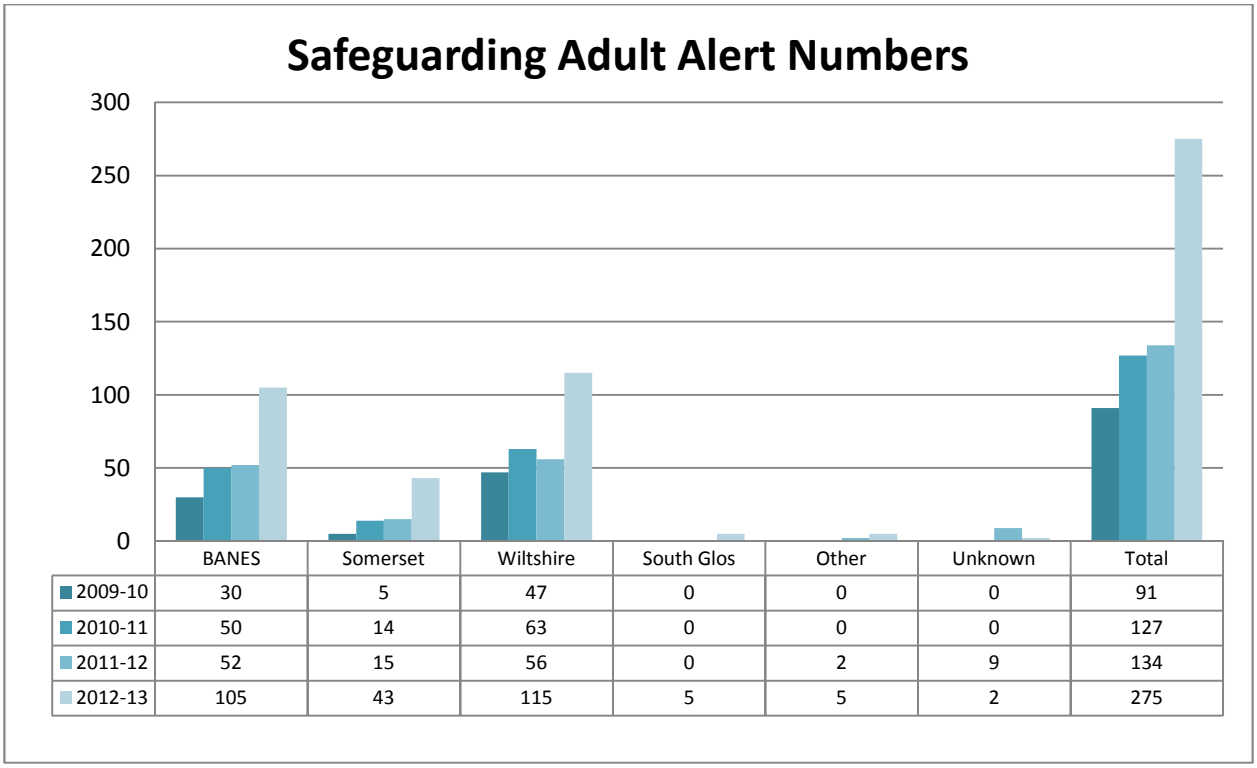
Structure and approach

The Royal United Hospital Safeguarding Adults group has been established for 7 years and consists of the following group members:

- Executive Lead, Director of Nursing
- Operational Lead, Matron for Critical Care Services
- Medical Lead, Consultant Geriatrician
- Sister for Quality Improvement for Mental Health & Learning Disability
- Senior Nurse for Quality Improvement & Adults at Risk
- Lead for Quality Assurance
- Head of Clinical Skills

The Executive Lead attends the Local Safeguarding Adults Board meetings. As per agreement at LSAB level, there is RUH representation from one of the Trusts Operational Leads at the Quality Assurance Sub group, with the other sub groups being represented by other acute Trust representation.

Over the past 4 years there has been a consistent rise in the number of alerts made to the Operational safeguarding leads.



	BANES	Somerset	Wiltshire	South Glos	Other	Unknown	Total
2009-10	30	5	47	0	0	0	91
2010-11	50	14	63	0	0	0	127
2011-12	52	15	56	0	2	9	134
2012-13	105	43	115	5	5	2	275

Achievements 2012-13

- Awareness of adult abuse and protection continues to increase across the organisation.
- Successfully ran “Deprivation of Liberty Safeguards” (DoLS) workshops for senior staff.
- Compliant with training targets for the delivery of Adult safeguarding Level 1
- Development and delivery of Adult Safeguarding “refresher” training at Level 2
- Half day induction training for all registered staff aligned to BANES /Sirona training matrix level 2
- Following CQC inspection in September 2012, the RUH is compliant with outcome 7.
- Positive outcome from the South West Partnership Dementia Peer Review in January 2012. The Trust was highly commended for being Dementia friendly.
- CRB checks compliance is 100% for all new staff.
- Root cause analysis undertaken on 100% of the most serious pressure ulcers at grade 3 and 4.
- Further development and growth of the existing Safeguarding “database”
- Establishment of a DoLS “database”.
- Development of and work against the Safeguarding Adults Work plan for 2012-13. This was written in alignment with the Self-Assessment Quality & Performance Framework for Adult Safeguarding, CQC essential standards for quality and safety, Training Matrix - BANES LSAB and RUH

Training

Subject	% compliance	All staff or selected
Safeguarding Adults RUH level 1	83.7%	All Staff
Safeguarding Adults RUH level 2	33.1%	Clinical staff

Adult safeguarding training at Level 2 for clinical staff has been offered since April 2012. A training implementation plan has been developed, with an internal trajectory for improvement towards target compliance of 85%. This trajectory is agreed and monitored by the commissioners also.

Key plans and objectives for safeguarding adults in the coming year

- To meet our training objectives for levels 2 and 3 as per our internal trajectory.
- Improved utilisation and interrogation of the safeguarding adults and DoLs "data bases", which will report into the Trust's Safeguarding Adults Forum.
- Randomised case note review to be undertaken quarterly and reported into Trusts Safeguarding Adults Forum
- Update Safeguarding Adults work plan for 2013-14 and work towards completing these objectives
- Full time named nurse for Adult Safeguarding (new appointment) to establish work programme

5.7. Salisbury NHS Foundation Trust

Structure and approach

Salisbury NHS Foundation Trust continues being an active member of the WSAB, supporting the multi-agency process to ensure Vulnerable Adults are safe from harm and abuse in Wiltshire.

Tracey Nutter, Director of Nursing is the Executive Lead for Children and Adult Safeguarding. Fiona Hyett, new Deputy Director of Nursing from September 2012, has replaced Lorna Wilkinson. Fiona has operational responsibility for Safeguarding Adults and sits on the WSAB. Gill Cobham, is Adult Safeguarding and MCA Lead and has responsibility for supporting staff through the safeguarding process, increasing awareness and multiagency liaison. Gill Cobham is a member of the Policy, Practice and Procedures Sub- Group. Assurance to the Trust Board is via reporting to the Clinical Risk Group and Clinical Governance Committee.

Awareness of Adult abuse and protection continues to increase across the organisation. There is strong multi-agency working between the Hospital, Social Care and the Police. We have an active Learning Disability Working Group with representation from NHS Wiltshire's Community Team for People with Learning Disabilities, Trust staff, Carers, and South Wilts Mencap. The Learning Disability Work Group has an annual work plan.

The Adult Safeguarding Lead Nurse and Named Nurse for Safeguarding Children continue to work closely and represent the Trust on Wiltshire's MARAC. Awareness raising around domestic abuse within the organisation continues.

Achievements during 2012-13

68 Safeguarding alerts were raised by the Trust, 16 Urgent DoLS authorized and a total 17 patients referred to the IMCA service from the Hospital and Social Care (SWAN cannot currently break this data down by county, so some may be for patients who live outside Wiltshire).

The organisation continues to make progress with the SW Adult Safeguarding Quality and Performance Framework action plan, Learning Disability work plan and Dementia Strategy. A further Dementia Peer review was completed in February 2013; the feedback was very positive.

CQC completed their unannounced scheduled inspection of the organisation in February 2013. All essential standards of quality and safety were met with the exception of staffing and medical records. CQC were concerned that the organisation 'did not have sufficient, experienced, qualified and skilled staff to meet people's needs effectively at all times' and that 'paper based confidential patient information was not protected effectively on some wards'. These were judged as having a minor impact on patients and an action plan had to be submitted to CQC by April 5th 2013.

Training

327 staff completed Safeguarding awareness training at Induction this year (includes Adult and Child Protection and Domestic Abuse). 80% of Trust staff have completed the Safeguarding e-learning package, and 78% the MCA e-learning package. This year a further 60 registered staff have completed in depth MCA training (includes DoLS) provided by an outside trainer

Key plans and objectives for safeguarding adults in the coming year

- Continue to embed work in relation to Learning Disabilities, Dementia and Domestic Abuse
- Safeguarding/ MCA/ LD training strategy and provision of 'in-house' training
- Safeguarding Committee, as part of the reporting/ governance structure in the Trust

5.8. Great Western Hospital

Structure and approach

The Chief Nurse is the Executive Lead for Safeguarding. There is also a Non-Executive Lead for Safeguarding. Both roles are to assure the Trust Board of the adequacy of the systems and processes which are in place (or which are required) to support effective safeguarding measures across the organisation.

The Deputy Chief Nurse is the Operational Lead for Safeguarding Adults at risk and also Chairs the Trust Safeguarding Children and Adults Forum, providing strong leadership that supports Directorates to make safeguarding integral to care. The Deputy Chief

Nurse represents the Trust on the LSAB. The Trust has representation on the Learning and Development Sub-group.

The Trust Safeguarding Children and Adults Forum is a multi-professional group that provides assurance to Patient Safety and Quality Committee (Sub-Group of the Trust Board) that the Trust is protecting children and adults at risk, are following multi-agency procedures, and meet identified national and local standards**.**

Achievements in 2012-13

A review conducted by the Internal Audit Services in October 2012 as part of the planned Trust programme, identified a number of weaknesses in assurance. Further, a self-assessment using an assurance framework published by the Department of Health in March 2011 has been conducted to review the robustness of the Trust's current arrangements for Adult Safeguarding. The key findings are summarised below:

Strategy & planning

The Trust has a number of good examples of planning to improve areas of work that impact for vulnerable adults including the Falls Prevention Strategy, Dementia Strategy Group and Learning Disability Forum work-plan. The Trust Safeguarding Forum terms of reference and agenda was reviewed and updated to ensure there is an appropriate balance of strategic and operational focus, and to be tasked with developing a strategic plan.

Systems & processes

A Trust policy for 'Safeguarding Adults at Risk' is available and aligns to the multi-agency policy and procedures developed jointly by Swindon and Wiltshire Local Safeguarding Adults Boards (LSABs). At the time of the audit, the policy was out of date and its contents were not sufficiently comprehensive. A review and update of the policy was conducted in line with the multi-agency policy and has been ratified through the Trust policy and procedure group.

The audit recognised that the Governance arrangements for Adult Safeguarding required further improvement. The current governance processes were not in place to capture referrals and monitor outcomes from investigation reports. At the time of the audit, systems to regularly and routinely report safeguarding activity and performance were not established. As of February 2013 new systems and processes were introduced that include the logging of all safeguarding referral on the Trust Clinical Incident reporting system.

The Trust Safeguarding Forum has worked with Governance colleagues to design and implement robust systems and processes, ensuring they align with LSAB requirements.

Workforce, culture & capability

An Adult Safeguarding Facilitator's post was developed to support and drive existing work for adult safeguarding. Resources are available for a limited period only and evaluation of the impact of the role will be required to ascertain whether a permanent role is required. In addition, funding has been agreed to provide an administrative

function to support Adult Safeguarding, including mental health, dementia and learning disabilities.

Partnerships and collaborative working

The Trust is represented at LSABs for Swindon and Wiltshire by the Deputy Chief Nurse, who attends appropriately and is well engaged with the wider agenda. The Trust is able to provide service information as required by the LSAB or commissioners.

In addition, the Trust works closely with our mental health providers AWP to provide an efficient and effective service that meet the service needs.

Staff training

The Trust has a responsibility to ensure that sufficient education and training is available and accessible for staff. Training is aligned to service and changing care needs to ensure that people are cared for by staff that are properly inducted, trained and qualified, who have the required knowledge and skills to do the jobs the service needs, whilst working effectively in a team. The audit mentioned above also identified that many staff, despite accessing the mandatory training, lacked confidence in fulfilling their role in Safeguarding. Additionally work to review the content of the training such that it has maximum impact on practice and staff knowledge is in development with the Trust academy and Local Safeguarding Leads.

Training will deliver a competent and capable workforce that will:

- Be able to explain the concepts of protection and vulnerability.
- Recognise the type of abuse and their related sign.
- Understand how to report concerns including whistle blowing.
- Take personal action to safeguard adults in their care

Safeguarding adults training is established as mandatory for all staff groups across the organisation and compliance has improved over the past 6 months with a Trust figure of 82.2% as of March 2013.

Key plans and objectives for safeguarding adults in the coming year

- To continue to review and further develop the Trust internal reporting systems and evidence learning from relevant safeguarding cases
- To review and further develop education and training and evidence that such training is having positive outcome
- To continue to raise the profile of safeguarding through the new Integrated Safeguarding annual forum and 'Big Conversation' month planned for June 2013
- Work is also needed to determine what training or development members of the Trust Board should receive such that they have an understanding of the requirements of the Trust and can discharge their duties in relation to Safeguarding Vulnerable Adults.
- To have supervision available and accessible for staff involved in Safeguarding Adults procedures and processes.

- To further strengthen the work of the Trust Safeguarding Children and Adult Forum through the operational sub-groups and the development of an overarching Safeguarding Adults Action Plan outlining local and national priorities and actions
- To perform an annual self assessment on the Trust position around safeguarding adults – December 2013

5.9. The Wiltshire Care Partnership

Structure and approach

The Wiltshire Care Partnership has been established as a joint initiative between commissioners and independent providers of 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.

Achievements during 2012-13

Although still in its first year, the Wiltshire Care Partnership has been able to recruit over 50% of independent care homes for older people making it the largest single representative body for independent care providers ever established in the county. It is funded through its members with support from Wiltshire Council.

Key plans and objectives for safeguarding adults in the coming year

As the Wiltshire Care Partnership progresses it is developing a range of services for its members which will support sustainability of their businesses. It will provide mentoring and advice to providers in order to make the best use of experience and promote best practice. The Partnership offers a valuable opportunity for commissioners and providers of care to work together to jointly address the challenges of meeting the needs of older people. Sharing intelligence, ideas and expertise will allow 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.

5.10. South West Ambulance Service Trust

This report is extracted from the Trusts annual report to the Trust's Quality Governance Committee.

Structure and approach

The Executive Nurse Director is the Executive Director accountable for safeguarding of vulnerable groups including children. This enables SWASFT to fulfil its functions in partnership with others and secure effective operation of LSAB functions and ensuring that the organisation is effectively engaged.

In addition, the Safeguarding Manager provides a safeguarding report to the Quality Governance Committee in order to provide safeguarding activity information to this

group, detailing progress against SCR action plans, legislation and trust safeguarding activity.

Achievements during 2012-13

- The Safeguarding Service workforce has increased to include a full time Manager successfully recruited and commenced on 2 January 2013.
- There are 2 Named Professionals who are dedicated to safeguarding as part of the acquisition.
- Recruitment is in progress to recruit an additional band 3 position to support the existing band 3 administration assistant.
- The 'memorandum of understanding' was agreed with all 28 Boards
- The governance framework reporting system has been strengthened by the Safeguarding Manager attending the Quality Governance Committee.
- Despite the challenges of the limited workforce at some points in the year, all SCR information was relayed as appropriate.
- The safeguarding referral system is more sophisticated to produce quality data.
- A successful Care Quality Commission inspection was undertaken on safeguarding in Jan 13.
- A training Strategy has been agreed
- The Allegations Policy has been agreed.

Key plans and objectives for safeguarding adults in the coming year

The priorities for the Safeguarding Service were decided at the whole team meeting in March 2013. These are:

- Ensuring the delivery of the Integrated Training
- Ensuring the running of a successful Safeguarding Operational Group
- Ensuring the appropriateness and quality of safeguarding referrals.
- Work plan to be guided by the South West Audit

5.11. Domestic Abuse

Governance

Wiltshire Community Safety Partnership provides the governance framework for reducing the prevalence and impact of domestic abuse in Wiltshire. Domestic Abuse (DA) reduction is a priority area within the Partnership Strategic Assessment and is identified in the Joint Strategic Needs Assessment for Wiltshire.

The multi-agency DA Reduction group (DARG) is responsible for the delivery and implementation of the DA strategy and Implementation plan.

Achievements during 2012-13

Multi Agency Risk Assessment Conference (MARAC)

MARAC is a multi-agency case conference meeting, held fortnightly, to discuss the 10% of Domestic Abuse cases assessed as being at greatest risk of harm. It agrees multi-agency action planning to support and safeguard victims and their families.

In 2012/13 278 cases were discussed and actions agreed at the Wiltshire MARAC, of which 23% were repeats. 391 children were dependents of the victims referred and 46% of referrals were from non police agencies.

Domestic Violence Protection Notice/Orders (DVPN/O) pilot

In July 2011 Wiltshire was selected to trial this new legislation also known as the 'Go Orders', representing a small force area, alongside Greater Manchester and West Mercia.

The purpose of the DVPN/O's – Go Orders is to:

- Create a *protective space* for the victim.
- Enable support services to *engage* with the victim; identify appropriate support interventions and prevent further violence and harm.
- *Remove* the perpetrator from the home using prohibiting conditions, *restricting* them from returning for up to 28 days.

From the start of the scheme to September 2013, in Wiltshire and Swindon there have been 236 DVPN's issued and 198 DVPO's granted, with 25 breaches.

Domestic Violence Disclosure Scheme (DVDS) pilot

In July 2012 Wiltshire was selected to trial the introduction of Domestic Violence Disclosure Scheme (DVDS) also known as Clare's Law. Wiltshire is one of four forces that will test two types of process for disclosing to an individual the previous violent offending history, by a new or existing partner, where it is deemed a pressing need by professionals.

This process will be triggered by i) a member of the public - 'right to ask' or ii) the police where a proactive decision is taken to disclose information to help safeguard and further protect an individual from harm - 'right to know'.

From the start of the trial to October 2013 in Wiltshire there have been 85 applications received, 59 'Right to Know' and 26 'Right to Ask', of these 15 proceeded to a disclosure being made.

Domestic Homicide Reviews (DHR)

DHRs were established on a statutory footing under section 9 of the Domestic Violence, Crime and Victims Act (2004), which came into force on the 13th April 2011. DHR's are managed within the governance of the WCSP.

A review is required to be taken in the event of a death of a person aged over 16 whose death has resulted from violence, abuse or neglect from a person they were in/or had had an intimate relationship with. Where a victim of a domestic homicide is aged 16-18, a child Serious Case Review (SCR) should take precedence over a DHR.

DHRs are opportunities for agencies and individuals to learn lessons to make improvements in the way they work, ultimately working to prevent future homicides.

Tragically, four domestic homicides occurred in Wiltshire between November 2012 and April 2013. These reviews are in progress and will be published in due course.

As a response to the domestic homicides, the Chair of the Wiltshire Community Safety Partnership mandated a Domestic Abuse Awareness Raising Campaign to commence in September 2013. The campaign will run for a year and will focus on raising awareness of the forms of abuse and routes for help and support.

Training

Wiltshire has developed a sustainable training programme covering 'An Introduction into DA Awareness' and 'Understanding the Risk Assessment Tool and Referral Route into MARAC' delivered by the MARAC Co-ordinator and the Independent Domestic Violence Advisor (IDVA).

Sessions are multi-agency for front line professionals, are always well supported and oversubscribed. Participants have included Housing Officers, Witness Service Volunteers, Education Welfare and Behaviour Support Assistants, Children's Centre staff and a wide range of health professionals including Paramedics, Heath Visitors, and First Response Aiders.

In 2012/13 a total of 195 multi-agency staff members were trained.

Key plans and objectives for safeguarding adults 2012-13

The refreshed DA Strategy and 12 month implementation plan has identified five priority areas for work:

Victims and Survivors: Swindon and Wiltshire agencies will work together in partnership to meet the needs of all victims and survivors to ensure access to quality appropriate support.

Children and Young People: to recognise the specific needs of and provide support for children and young people whose lives are affected by domestic abuse.

Perpetrators of domestic abuse: to ensure that perpetrators are held accountable for their actions and brought to justice, using both supportive and enforcement approaches to reduce offending behaviour and harm.

Training and Awareness Raising: to increase the local communities and organisations understanding and awareness of the extent and impact of domestic abuse.

Future Development: in both statutory and voluntary agencies, sharing skills, resources and good practice to reduce the prevalence of domestic abuse.

5.12. Wiltshire Fire and Rescue Service

The Fire and Rescue Service is just joining the Board in 2013, but it is useful to outline its role in relation to safeguarding. The Service's contact with those who are vulnerable is usually low risk in terms of abuse and neglect, but these are the very people who will, if not supported, become high risk.

The Service is currently reviewing its policies and procedure for safeguarding children and adults and will deliver bespoke awareness training to all staff during the next

financial year. Senior Managers and specialist roles will get enhanced safeguarding training commensurate to their role.

A case study of the kind of links that exist between the service and safeguarding activity can be found at Appendix 5.

6. Local progress in relation to national requirements

6.1. 2012-13 was a year when many substantial national reports and other publications appeared with relevance to Safeguarding work, which the Board has noted and responded to as appropriate. Between June and August 2012 the following were published:

- 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*
- HM Government (July 2012) *Draft Care and Support Bill*
- DH (July 2012) *Consultation on New Safeguarding Power*
- NHS South of England (August 2012) *Report of the NHS Review of commissioning of care and treatment at Winterbourne View*

6.2. Most of these arose from the abuse that occurred at Winterbourne View Hospital, and the Board's response to this is outlined in paragraph 3.3 above, and partner reports also refer to their own actions. Following consultation, the Care and Support Bill was renamed the Care Bill and has started its progress through parliament. It brings safeguarding adults work into a legal framework for the first time and requires each local authority to establish a Safeguarding Adults Board. It also makes provision for Safeguarding Adults Reviews to be carried out when it appears that neglect or abuse has contributed to the serious injury or death of an adult.

6.3. In December 2012 the Association of Directors of Adult Social Services (ADASS) published national guidance on Out of Area Safeguarding Arrangements, which the WSAB has adopted. This creates a consistent approach to communication and responsibilities for safeguarding where people are living in an area other than that of the local authority or NHS organisation which is responsible for their care and support.

6.4. Other publications in the latter half of the year and early in the new financial year included:

- DH (February 2013), *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry and Executive Summary,*
- ADASS (March 2013), *Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services*

- NHS England (March 2013), *Safeguarding Vulnerable People in the Reformed NHS, Accountability and Assurance Framework*
- DH (May 2013), *Statement of Government Policy on Adult Safeguarding (*Updated from the May 2011 statement
- Local Government Association, ADASS and Social Care Institute for Excellence (SCIE) (May 2013), *Making Safeguarding Personal*

6.5. The WSAB has had initial discussions about the Mid-Staffordshire report, has noted the ADASS, NHS England and DH publications, and will need to address *Making Safeguarding Personal* in the coming months.

7. Priorities for the year 2013-14

These priorities reflect national developments and local objectives. The Board's Business Plan integrates these priorities with other existing work and sets out timescales for implementation. During the year, the Board will also receive feedback from the four Domestic Homicide Reviews that are underway in the county, led by the Community Safety Partnership, and this may identify further priority activities for the WSAB.

Overall Priorities

- ❖ Implement agreed actions arising from the Winterbourne View and Mid-Staffordshire reports
- ❖ Establish the service user reference group and, in partnership with its members, develop its contribution to the work of the Board and safeguarding system.
- ❖ Continue work to develop a more structured approach to the involvement of informal carers in the work of the Board and safeguarding system
- ❖ Continue to develop a communications strategy 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. Update web-based information to support the strategy.
- ❖ Carry out the agreed Serious Case Review to a high standard.
- ❖ Develop further the new quality assurance reporting structure.
- ❖ Contribute to the Peer Review commissioned by Wiltshire Council
- ❖ Respond to the passage of the Care Bill and related regulations and guidance when issued, preparing the Board to move onto a statutory footing.

Partner Priorities

In addition to supporting the delivery of the Board's overall priorities, partner agencies will be working on their organisational safeguarding priorities. Where priorities are stated in the reports in section 5, their specific activities and concerns also show some common themes:

- ❖ A range of training, mentoring and development work
- ❖ Actions to consolidate or improve management and governance arrangements

- Further development of the use of data, audit and case review
- Quality assurance across different aspects of partners' responsibilities

Appendices **Appendix 1**

Business Plan 2013-15 (including WSAB Terms of Reference)

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.

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[7].

2. Underpinning Principles

The Board will achieve its role by implementing the national principles of adult safeguarding[8], 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:

[7] A list of current guidance at the time of this revision is at Appendix 1

[8] 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 • Corporate Director • Service Director Adult Care Commissioning • Head Specialist Commissioning, and Safeguarding
Clinical Commissioning Group	• Director of Quality and Patient Safety
Avon and Wiltshire Mental Health Partnership NHS Trust	• Clinical Director for Wiltshire
Wiltshire Police	• Superintendent with responsibility for Public Protection
Salisbury Hospital NHS Foundation Trust	• Deputy Director of Nursing
Royal United Hospital Bath	• Director of Nursing Services
Great Western Hospital Foundation NHS Trust	• Deputy Chief Nurse
NHS Community Services	• Via GWH Representative
Wiltshire Care Partnership	• As nominated

Domiciliary Care provider representative	• As nominated
Great Western Ambulance Service	• Clinical Standards Manager
Probation Service	• Director of Operations
Carer Representation	• Under development
Service User Representation	• Under development
Community Safety Partnership	• Public Protection Manager, Wiltshire Council

Arrangements are being made for the views of service users and carers to be effectively represented in the Board's work, either by direct membership of the board and its sub-groups or by reference group or similar arrangements.

The Compliance Manager from the Care Quality Commission attends annually.

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 July 2013

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 South of England (August 2012) *Report of the NHS Review of commissioning of care and treatment at Winterbourne View*

ADASS (December 2012) *Out of Area Safeguarding Arrangements*

DH (February 2013), *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry and Executive Summary,*

ADASS (March 2013), *Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services*

NHS England (March 2013), *Safeguarding Vulnerable People in the Reformed NHS, Accountability and Assurance Framework*

DH (May 2013), *Statement of Government Policy on Adult Safeguarding (*Updated from the May 2011 statement

Local Government Association, ADASS and Social Care Institute for Excellence (SCIE) (May 2013), *Making Safeguarding Personal*

Bournemouth University and Skills for Care (2012) *National Capability Framework for Safeguarding Adults*

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 within the South West Self Assessment Quality & Performance Framework for Adult Safeguarding. This was developed in partnership with the Strategic Health Authority and approved by the South West ADASS Safeguarding Adults Advisory Group which has health, social care, CQC and police representation.

The Quality & Performance Framework Domains and Outcome Measure 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:

- Implement agreed actions arising from the Winterbourne View and Mid-Staffordshire reports
- Establish the service user reference group and, in partnership with its members, develop its contribution to the work of the Board and safeguarding system.
- Continue work to develop a more structured approach to the involvement of informal carers in the work of the Board and safeguarding system
- Continue to develop a communications strategy 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. Update web-based information to support the strategy.
- Carry out the agreed Serious Case Review to a high standard.
- Develop further the new quality assurance reporting structure.
- Contribute to the Peer Review commissioned by Wiltshire Council
- Respond to the passage of the Care Bill and related regulations and guidance when issued, preparing the Board to move onto a statutory footing.

Section 1 – Actions, Timescales and Lead Responsibility

NB – Some actions in this plan draw on the Action Plan the WSAB had developed in response to the Winterbourne View Hospital Serious Case Review and related reports, and details can be found in that plan.

Outcome 1. Prevention & Early Intervention Outcome: 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	a) Receive a report about the updated Action Plan (See 4.1 below) arising from the joint work of the NHS and Wiltshire Council (the "County Action Plan") and agree specific actions for the board arising from that. (WVH)	June '13	George O'Neill and Jacqui Chidgey-Clark
1.2 Performance Management systems record and indicate the potential for vulnerability and intervention	a) Confirm performance management and quality assurance system for the Board. b) Develop a system to identify and track people who may be at risk of harm. c) Consider whether it is possible to identify the potential links between increased financial pressures (pay levels and welfare benefits) and increased likelihood of people being at risk.	June '13 November '13	George O'Neill LA to lead Link to B&NES work on this

1.3 Policies and procedures are in place to prevent unsuitable people from working with vulnerable adults	a) Keep HR policies and procedures and their implementation under review, including whistle-blowing. • Identify a means of reporting back on this. • Deliver information to provide assurance	January ’14 March ’14	GO’N/ MS All
1.4 Steps are taken to prevent or reduce risk of abuse within service settings	a) WSAB to inform itself about AWP’s response to WVH report recommendations on enabling community living. b) Receive a report on responses providers are making to the WVH recommendations directly relevant to them. c) Agree and implement a response to the WVH report recommendation that LSABs and other stakeholders should regard hospitals for adults with learning disabilities and autism as high risk services.	September ’13 September ’13 June ’13	AWP Board representative Matthew Airey
Outcome 2. Responsibility & Accountability Outcome: 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	a) Provide a financial statement and breakdown of costs for the Safeguarding Adults Board. b) Ensure continued commitment from partners to the Board	June ’13 Ongoing	MS/ GO’N Board meetings

strategic leadership and address - **prevention of abuse and neglect** - **promotion of wellbeing and safety** - **effective response to instances of abuse & neglect when they occur**	and its sub-groups c) Support and monitor smooth transition of safeguarding work from the PCT to the Clinical Commissioning Group. d) Implement the actions agreed by the Board in response to recommendations of the Winterbourne View reports e) Respond as appropriate to further development of the Care Bill and any consultations on it.	Review at Dec '13 WSAB Specifics to be agreed TBC	MS/JC-C/ LAT
2.2 There are robust and current Local Multi-Agency Policies & Procedures for safeguarding adults that are in accordance with statutory requirements	a) Launch the revised policies and procedures b) Use the regular SAMCAT reports to identify any problems about quality of hospital safeguarding investigations. (WVH)	April '13 Ongoing	SAMCAT and QA sub-group
2.3 Clear leadership and accountability structures are in place and visible throughout the organisation	a) Continue to monitor organisational changes and their impact on safeguarding leadership in partner organisations. b) Present WSAB annual report to Health and Wellbeing Board and Wiltshire Council Cabinet c) Confirm partner organisation Executive reporting arrangements for safeguarding activity d) Consider Memorandum of Understanding between WSAB and Wiltshire Care Partnership, once MoU with Wiltshire	At each meeting Late 2013 March 2014 TBC	All MS MS

	Council has been established.		
2.4 Professionals who in the course of their work come into contact with vulnerable adults and their carers are aware of their safeguarding responsibilities	a) Contact Healthwatch as it is established to discuss its understanding of and influence on safeguarding. b) Undertake an audit of training staff receive which focuses on Safeguarding Adults and Mental Capacity Act c) Arising from WVH recommendations about A & E contact, receive report from the CCG about their action on this. d) Learning and Development Group to report on staff training audit	July 2013 September '13 TBC TBC	MS Jacqui Chidgey-Clark L & D sub-group

Outcome 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			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
3.1 There is a comprehensive accessible public information and advice about keeping safe and what constitutes abuse of vulnerable adults	a) Develop a communications strategy jointly with the Children's Safeguarding Board to support awareness raising and good information sharing across all Wiltshire's communities; update web-based information to support this. b) Contact Healthwatch as it is established to discuss its understanding of and influence on safeguarding.	September '13 July '13	Communications & Publicity sub-group MS

Outcome 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			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
3.2 The involvement and feedback from patients, people using services and their carers is an integral part of the design, commissioning and delivery of safe services	a) Develop a more structured and comprehensive approach to the involvement of service users in the work of the Board and safeguarding system. b) Develop a more structured and comprehensive approach to the involvement of informal carers in the work of the Board and safeguarding system. c) Get assurance from partners about their arrangements for involvement and the development of person-centred approaches. • Collated report on organisations' actions eg references in strategic plans, acute hospital Friends and Family test outcomes.	September '13 December '13 December '13	MS / WSUN MS / Carers Wiltshire CM

Outcome 4. Responding to Abuse & Neglect Outcome: 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	a) Report the results of case audits on a quarterly basis to the Board b) Receive a report about the updated Action Plan) arising from the joint work of the NHS and Wiltshire Council (the "County Action Plan") and agree specific actions for the board arising from that. (WVH) c) SAB will focus on raising awareness about whistle-blowing with and through: • Providers • The general public • Carers forum • Information available to staff in all settings • Via care planning d) The duty of professionals to report concerns to be included in safeguarding training. e) Develop WSAB member understanding of inter-relationship between HR law and regulation and safeguarding in provider organisations.	Quarterly from June '13 June '13 Next Comms and Publicity Task Group meeting ASAP December '13	QA Sub-group GO'N and JC-C Comms and Publicity Task Group L & D sub-group MA/MS/others as appropriate
4.2 If the mental capacity to make a specific decision	a) Arising from the WVH report recommendations on mental capacity, DOLs and Mental Health Act		

Outcome 4. Responding to Abuse & Neglect Outcome: 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**
relating to the safeguarding process cannot be assumed a Mental Capacity Assessment is undertaken as required by the Mental Capacity Act (MCA) 2005	responsibilities: • Monitor transition of supervisory body responsibilities from NHS Wiltshire to Wiltshire Council • Formulate request to (i) council team and (ii) each hospital provider for a baseline report about their arrangements • Reports come back to SAB • Assess sufficiency of resource to respond and promote wider recruitment of NHS staff and LD colleagues to BIA role	April '13	To be confirmed by JC-C ?MS
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.	a) Undertake a feedback survey for people experiencing the safeguarding process b) Audit implementation of the provision in the revised policy and procedures for the involvement of the subject of the abuse.	February 2014	
4.4 Adult Safeguarding Investigations are	a) A review of current safeguarding resources is undertaken to assure that there is sufficient capacity within the	October 2013	Service Director

Outcome 4. Responding to Abuse & Neglect Outcome: 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**
appropriately resourced and supported	safeguarding system.		

Outcome 5. Training & Professional Development Outcome: 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 vulnerable adults have been appropriately trained according to their role	a) Implement SAB Strategy for Competence Development • Establish arrangements to monitor training • Identify SAB's own training priorities and use Development Day to start to address • Focus on Learning development, implementing principles of transferring learning into practice b) Review training available to Care Managers and senior managers with responsibilities to investigate safeguarding allegations or incidents within provider organisations	Ongoing September '13 Ongoing December '13	L & D sub-group Chair/ Kim Holmes L & D sub-group MA/ L & D sub-group
5.2. All staff and volunteers have the	a) Safeguarding adults training is competency based, in line with the National Capability Framework for Safeguarding Adults	Ongoing	L & D sub-group

Outcome 5. Training & Professional Development Outcome: 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**
appropriate knowledge and competencies in relation to 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 – for 2013/14 including Winterbourne View Hospital & Francis Reports	Ongoing Sept 2013	L & D sub-group L & D sub-group
5.3 Staff use routine processes to enable people to acknowledge when they might be at risk and signpost them to effective support	a) Evidence of safeguarding alerts from a wide range of sources reported to the Board as part of the quality assurance framework	Ongoing	QA sub-group

Appendix 2

Board Membership and Attendance

Organization	Designated Member	June 2012	Sept 2012	Sept 2012 Dev Day	Dec 2012	Mar 2013
Independent Chair	Margaret Sheather	✓	✓	✓	✓	✓
Wiltshire Council - DCS	James Cawley	✓	A	✓	✓	✓
Wiltshire Council - Safer Communities	Pippa McVeigh	✓	✓	A	A	A
Wiltshire Council - Commissioning	George O'Neill	Ap-R	✓	✓	✓	✓
Wiltshire Council - Housing	Nicole Smith (to Sept 2012)	A			n/a	n/a
Wiltshire Council - Cabinet	Cllr Jemima Milton		✓	✓	A	A
Registered Nursing Homes	Matthew Airey	✓	✓	✓	✓	Ap-R
Wiltshire Police	Supt. Jerry Dawson	✓	✓	✓	✓	Ap-R
AWP	Mark Dean	✓	✓	✓	✓	✓
CQC (annual only)	Karen Taylor	n/a	✓	n/a	n/a	n/a
NHS Wilts & BANES	Mary Monnington	Ap-R	Ap-R	Ap-R	Ap-R	Ap-R
Great Western Hospital	Robert Nicholls	Ap-R	Ap-R	A	✓	✓
Great Western Ambulance Service	Sue Smith					
RUH Bath	Francesca Thompson (to Dec 2012) Mary Lewis (from Mar 2013	✓	✓	A	✓	✓
Salisbury NHS Foundation Trust	Lorna Wilkinson (to Sept 2012) Fiona Hyett (from Dec 2012)	✓	Ap-R	Ap-R	✓	A
Wiltshire Probation Trust	Lynne Wootton (to Dec 2012)	Ap-R	A	A	✓	
Domiciliary Care Provider	Helen Woodland (Aster Living)	✓				

Key: ✓ = present; A = apologies given; Ap-R = substitute attended.

Management Information Report on Safeguarding Adults April 2012 – March 2013

1. Overview

Figure 1 shows alerts over two 12 month periods (2011/12 and 2012/13) however it should be noted that 2012/13 data now includes figures from large scale investigations (LSIs) and so these year-on-year figures are not wholly comparable.

There were **1,686** alerts in the 12 months from April 2012, averaging 141 per month. This is a rate of 45.9 alerts per 10,000 of the county's population aged 18 and over.

2. Alerts

As stated above, there were 1,686 alerts during the past year:

Figure 1 Number of alerts by month

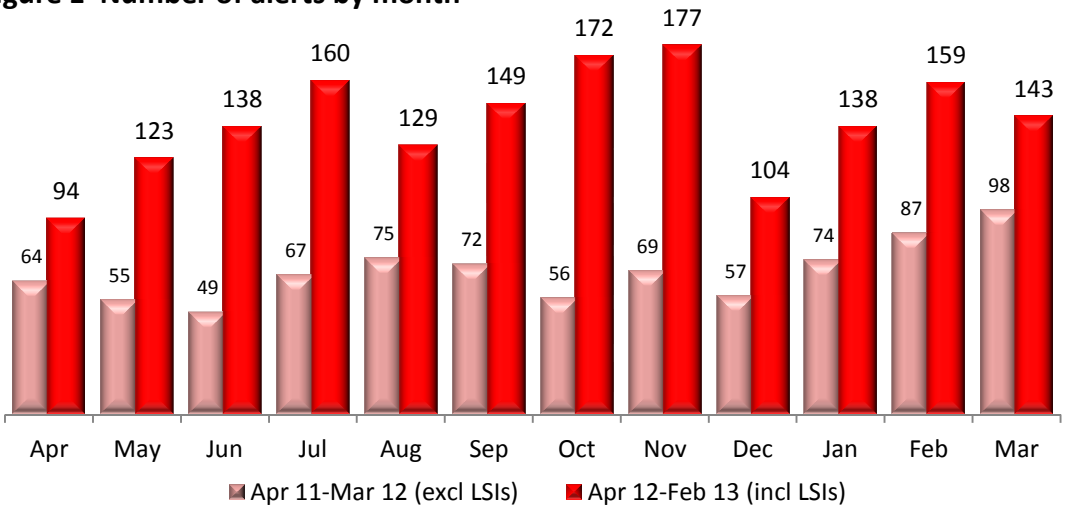


Table 1 Average number of alerts:

12 months:	1 Apr 12 – 31 Mar 13	140.5 alerts per month (1,686/12)

Alerts dealt with by each team are as follows:

Figure 2 Alerts by Allocated Team (12 month period)

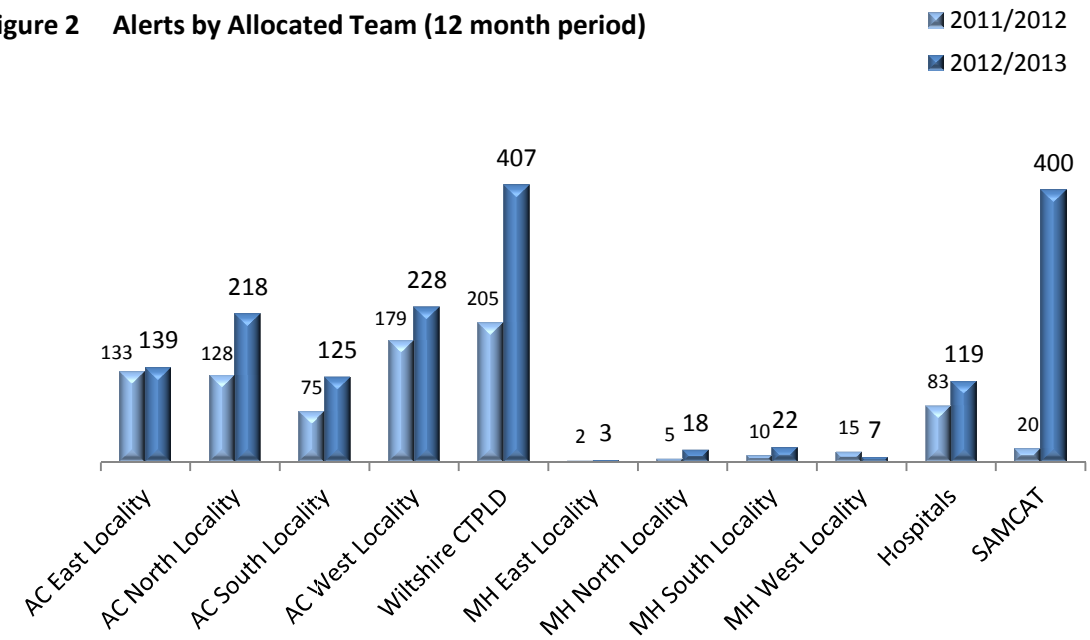
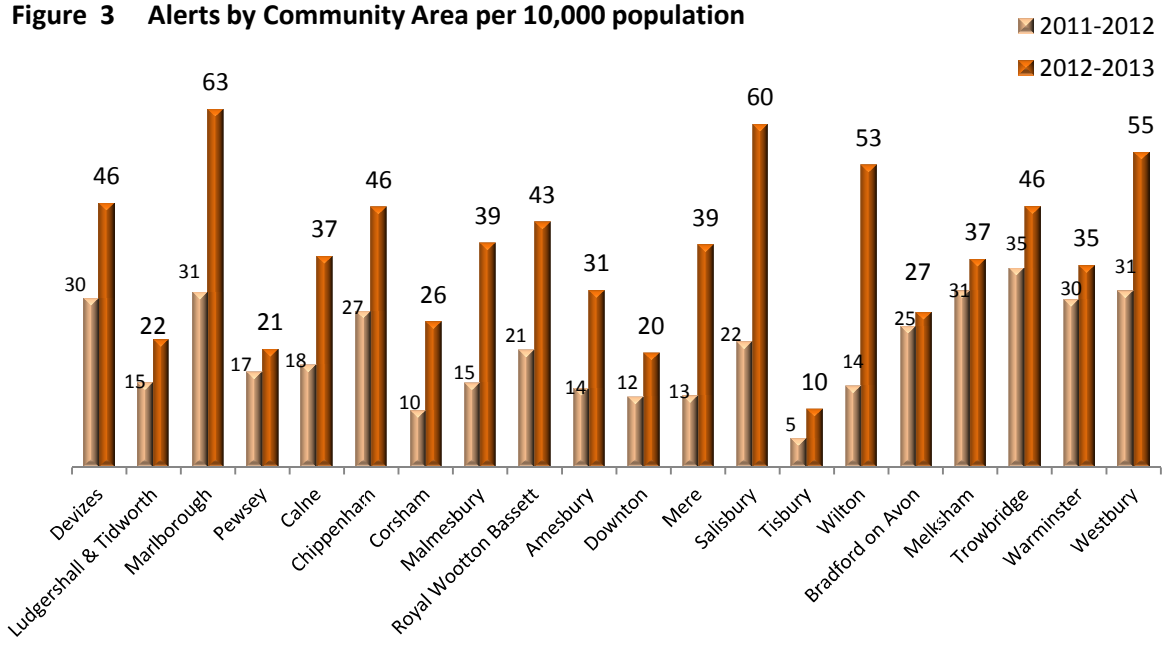


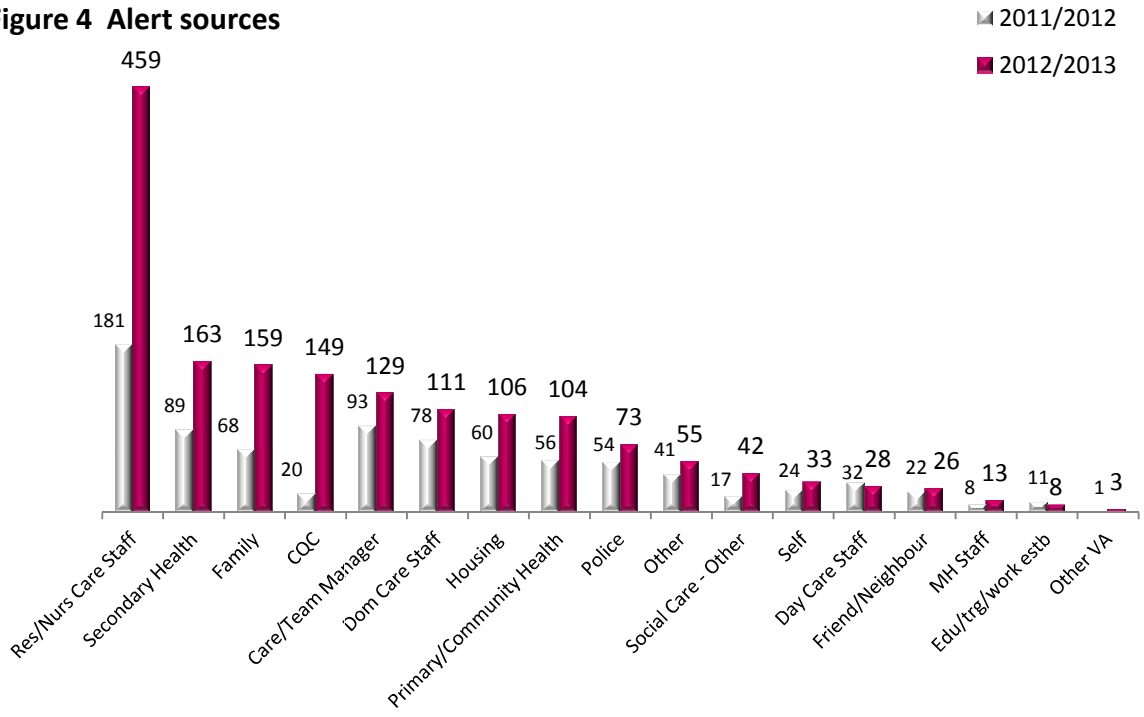
Figure 3 gives the number of alerts per community area and is shown as being 45.9 per 10,000 population (aged 18 and over) to show a comparison:

Figure 3 Alerts by Community Area per 10,000 population



Alerts are received from a range of sources as shown in Figure 4

Figure 4 Alert sources



'Care Manager/Team Manager' includes social workers, occupational therapists and care co-ordinators. 'Secondary Health Staff' can be hospital staff or other non-primary health staff. 'Primary/Community Staff' are GPs, district nurses and health visitors. 'Other' can be anonymous calls, the Court of Protection, a professional (e.g. solicitor, psychotherapist, etc), school staff or a local authority employee not employed as a care manager or care team manager.

3. Vulnerable Adults Information

Figures 5 – 10 show information about the people who were the subject of the alerts received.

Figure 5 Gender by age group

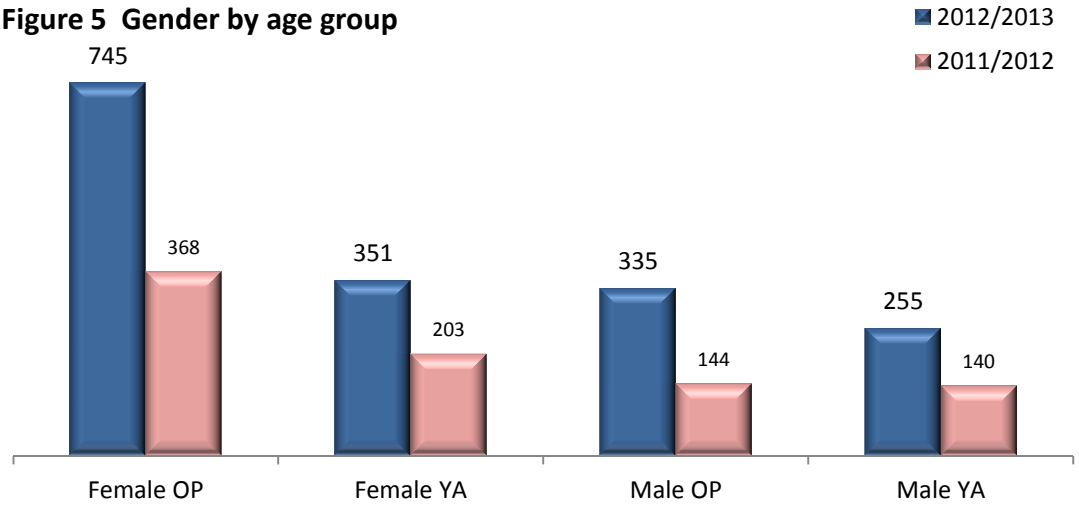
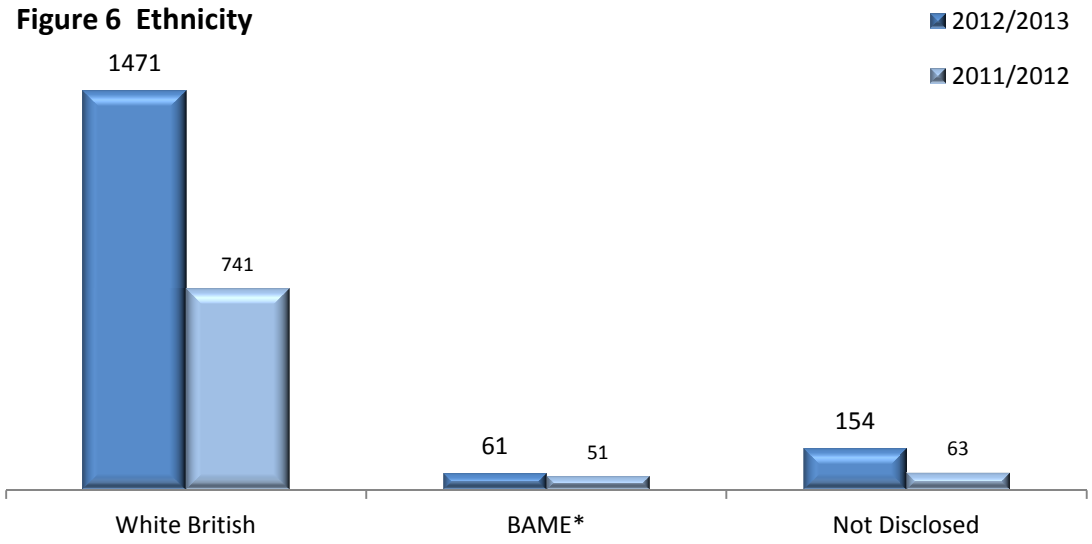


Figure 6 Ethnicity



(*BAME = Black, Asian and Minority Ethnic)

Figure 7 Client categories

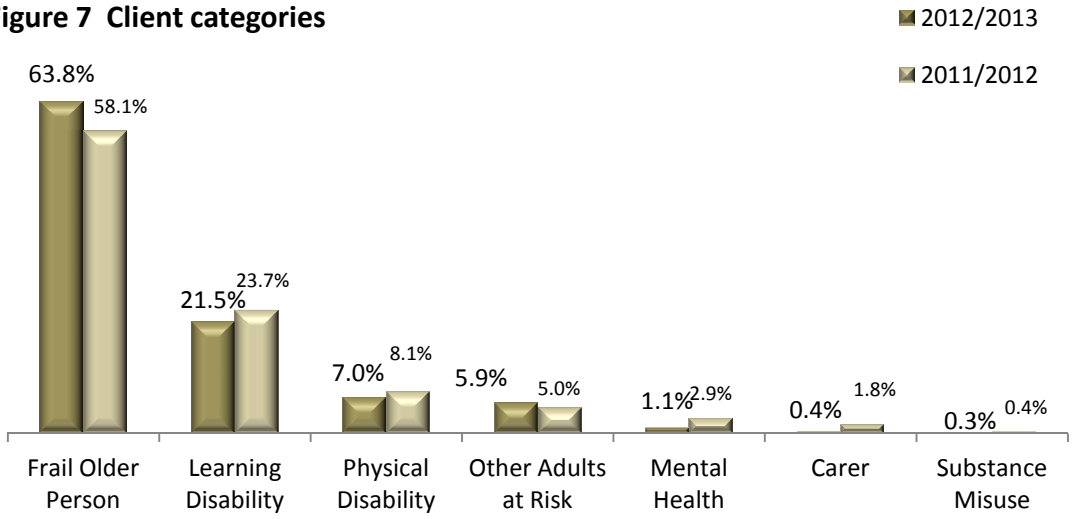
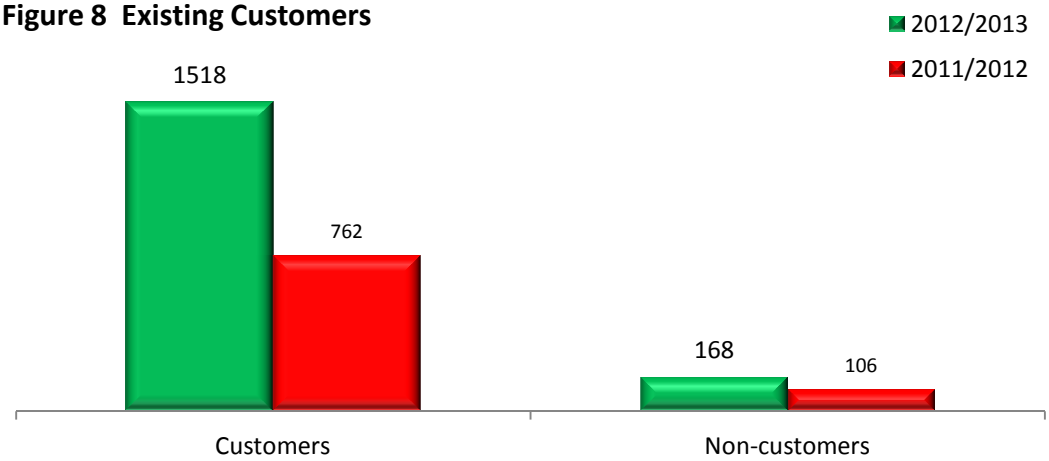
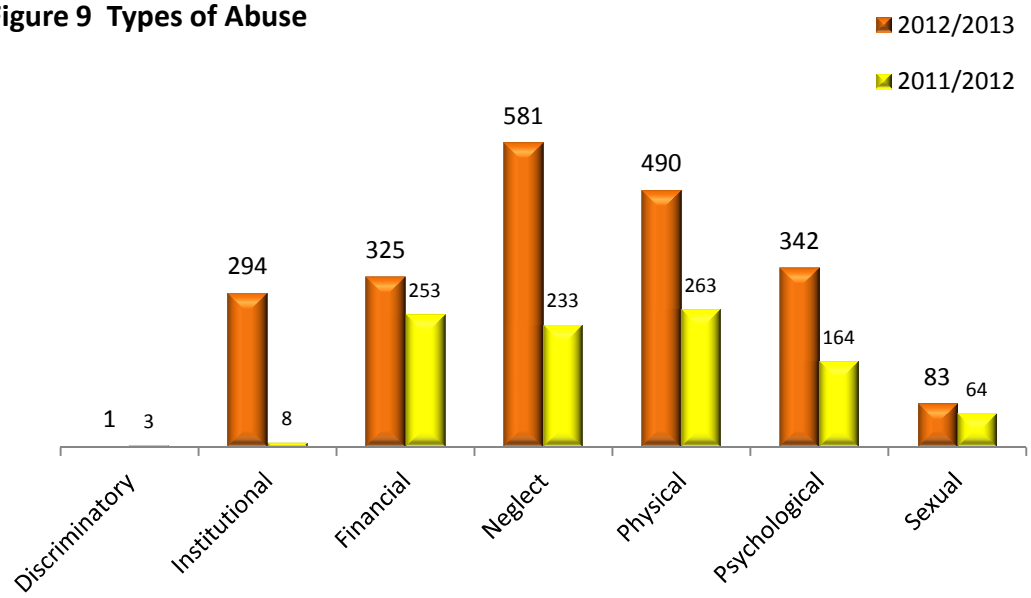


Figure 8 Existing Customers



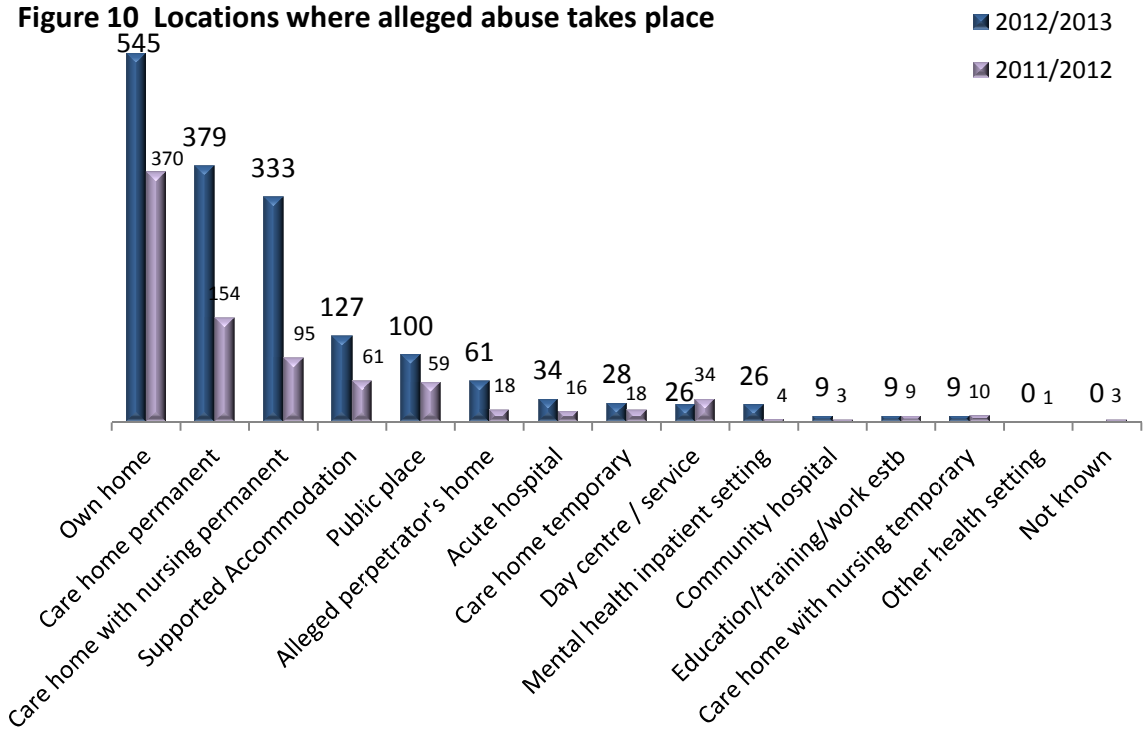
Each alert can involve more than one type of abuse. Out of 1,686 alerts, 298 were 'multiple'.

Figure 9 Types of Abuse



Adult abuse occurs in many different places, although primarily this takes place in the vulnerable adult's home:

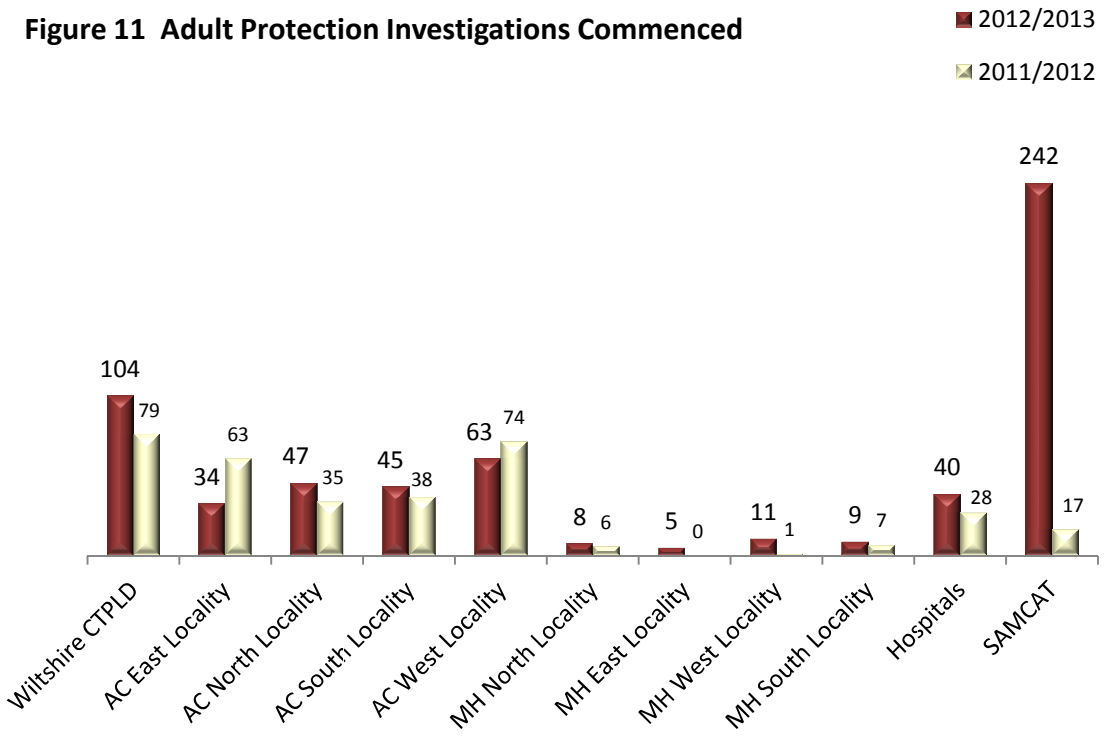
Figure 10 Locations where alleged abuse takes place



4. Investigations

A total of **608** Adult Protection Investigations were *started* during 2012/2013:

Figure 11 Adult Protection Investigations Commenced



Of the investigations commencing during this time, 28% were not substantiated and 5% were undetermined/ inconclusive. A further 20% of the investigations that had commenced during this reporting period had not been completed by the end of this time; this is due in the main to investigations starting towards the end of the reporting cycle.

During this 12 month period **589** investigations have been *completed* (some of these investigations may have begun prior to this time whilst others will have commenced towards the end of the period):

These investigations concluded:

Table 2 Investigation outcomes:

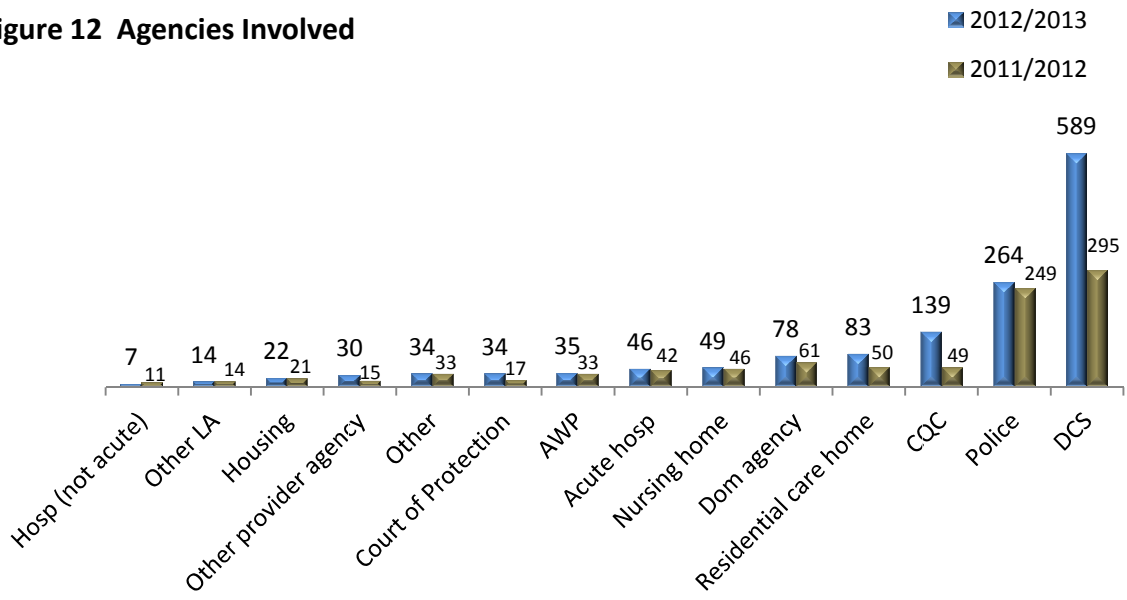
Not determined / inconclusive	40	6.8%
Not substantiated	178	30.2%
Substantiated	371	63.0%

Table 3 Investigation Conclusion:	2010/11	2011/12	2012/13
Substantiated	138	124	340
Partially Substantiated	3	1	31
Not Substantiated	142	136	178
Not Determined	39	49	40

Investigation Conclusion ratios:			
Substantiated	43%	40%	58%
Partially Substantiated	1%	0%	5%
Not Substantiated	44%	44%	30%
Not Determined	12%	16%	7%

Many agencies are necessarily involved in the investigations and where there is a high number of multiple-agency involvement; this demonstrates excellent inter-agency working on Safeguarding issues:

Figure 12 Agencies Involved



The nature of the alleged abuse will determine the outcome and Table 3 reflects the fact that in 127 instances, there was more than one outcome for the alleged subject of the abuse:

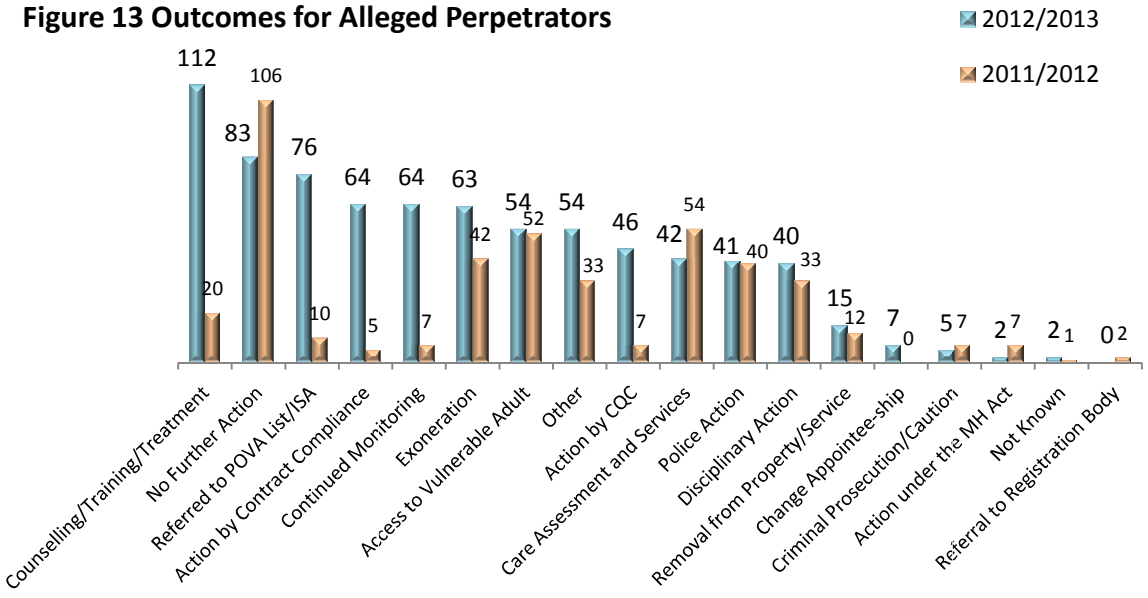
Table 4 Outcomes for alleged subject of abuse

Action	Not Determined	Concerns not substantiated	Substan-tiated	Total

Access to the Alleged Perpetrator	5	11	39	55
Access to Finances	9	13	28	50
Advocacy	2	4	13	19
Application to Court of Protection	7	9	19	35
Change of Appointee-ship	0	1	1	2
Community Care Assessment and Services	13	47	60	120
Civil Action	0	0	0	0
Counselling/Support	2	6	21	29
Guardianship/Action under the Mental Health Act	0	1	3	4
Increased Monitoring	9	42	68	119
Moved to Increased/Different Care	0	1	9	10
No Further Action	13	54	20	87
Other	1	6	4	11
Referral to MARAC	0	0	0	0
Removal from Property or Service	2	7	11	20
Review of Self Directed Support (IB)	0	0	0	0
Serious Case Review	0	0	0	0
Multiple Outcomes	11	40	76	127

Following the investigation, outcomes for alleged perpetrators were as follows:

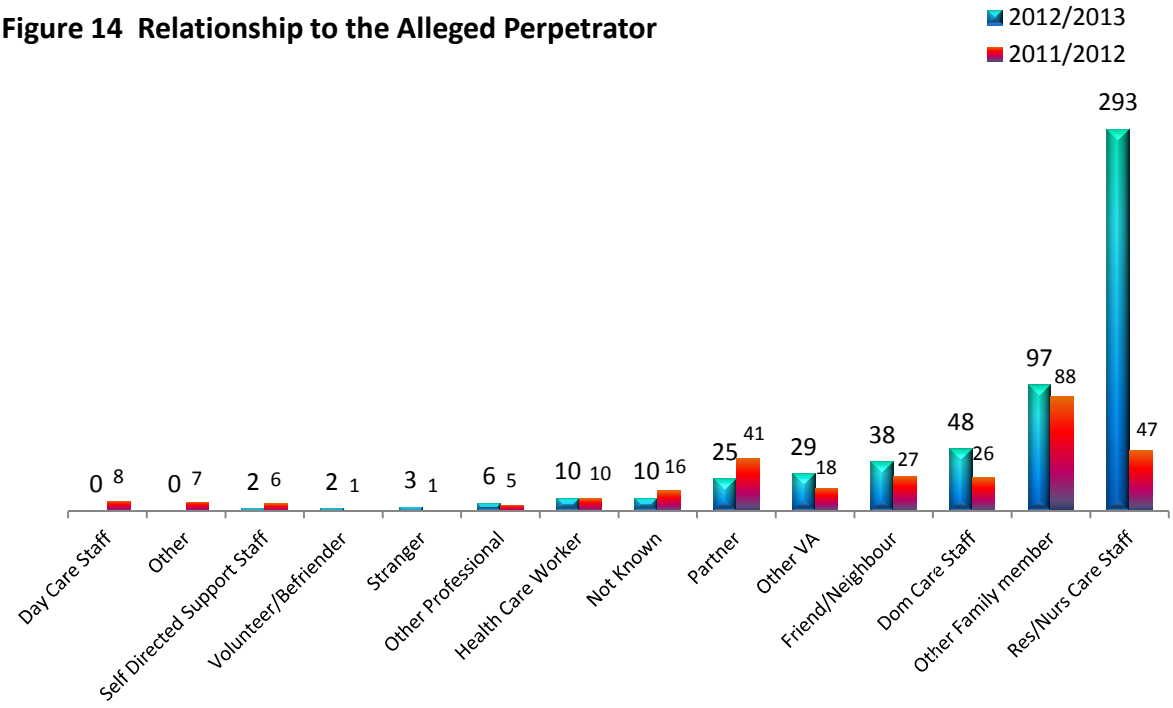
Figure 13 Outcomes for Alleged Perpetrators



Outcomes for alleged perpetrators can also be a multiple of 2 or more outcomes, which has occurred in 126 of these cases during 2012/2013.

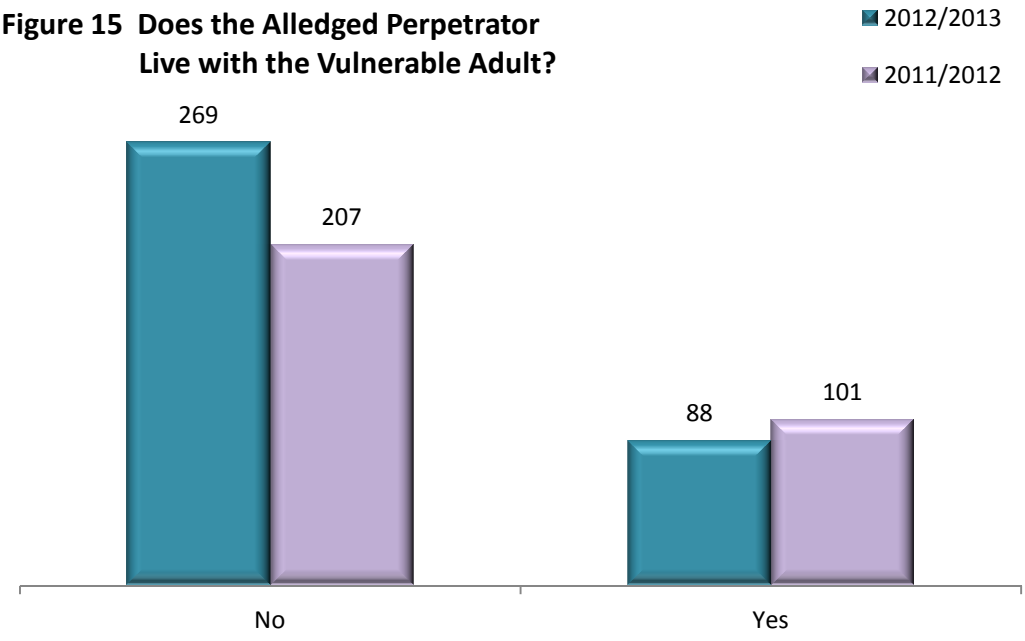
The relationship of the alleged perpetrator to the vulnerable adult can be anything from a partner or family member, to a complete stranger:

Figure 14 Relationship to the Alleged Perpetrator



In 88 cases, the alleged perpetrator is (or was at the time of the alleged abuse) living with the Vulnerable Adult:

Figure 15 Does the Alledged Perpetrator Live with the Vulnerable Adult?



The alleged perpetrator was the main family carer to the vulnerable adult in 37 instances.

Table 5: Relationship of Alleged Perpetrator to the Vulnerable Adult(alerts which became investigations):

	2010/11	2011/12	2012/13
Partner	43	37	26
Other family member	96	100	99
Health Care Worker	7	12	10
Volunteer/ Befriender	2	1	2
Social Care Staff - Total	72	121	368
Of which: Domiciliary Staff	28	34	54
Residential Care Staff	44	73	311
Day Care Staff	0	8	0
Social Worker/Care Manager	0	0	0
Self -Directed Care Staff	0	6	3
Other Social Care Staff	0	0	0
Other professional	5	4	7
Other Vulnerable Adult	25	22	38
Neighbour/Friend	33	31	40
Stranger	3	0	4
Not Known	15	13	14
Other	6	7	1

Appendix 4

Glossary of Terms and Definitions[9]

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.

[9] 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.

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 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

Appendix 5

Case Studies

One

A 56 bedded nursing home specialising in supporting people with dementia failed many standards in its CQC inspection. The Commissioning team worked with the home to try to support and address some of the standards that had been failed. However, it became clear that there were safeguarding issues which could not solely be addressed via commissioning and that residents may be at risk of significant harm. SAMCAT commenced a whole home investigation. The home had great difficulties in engaging with the process. SAMCAT uncovered many areas where there were risks to residents. They undertook unannounced visits to the home in order to ensure residents were being protected and worked with the home over a period of time to ensure they addressed the concerns, including putting in place training for staff. The home owners appointed a new manager who gradually addressed the issues being raised by SAMCAT and were able to meet all of the CQC standards. If this piece of work had not been undertaken all of the residents may have had to move home with all of the risks that are well known about moving older people with dementia.

Two

A small 12 bedded residential home caring for people with dementia failed many of its CQC standards and CQC made a referral to SAMCAT who commenced a whole home investigation. They uncovered major risks for residents including no care planning, poor environment, no activities, poor medication management, lack of management, no incident reporting and poor menu planning. The risks were so great that SAMCAT advised that all residents should be moved to safer environments. All residents were assessed and moved to more appropriate homes and the home under investigation closed.

Three

From Wiltshire Fire and Rescue Service

“We received a call to a small fire in our responding area. The fire was out when we arrived with slight smoke logging which was ventilated by the fire fighters.

There was one adult and one young child living in the property. The property was in a generally poor state of cleanliness, cigarette ends discarded throughout, there are no carpets in any of the areas and no food in the fridge. There is nothing to suggest there was any abuse or any deliberate neglect however the Fire Service contacted the Housing Officer and Social Services to get help and support for the family. This is good evidence of a partnership approach to ‘early help’ for a vulnerable family.”

Appendix 6

Relative Responsibilities of the CCG and NHS England

Both CCGs and the NHS England are statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect.

Both CCGs and the NHS England have a statutory duty to be members of Local Safeguarding Children Boards (LSCBs) and are expected to be fully engaged with local Safeguarding Adults Boards (SABs), working in partnership with local authorities to fulfil their safeguarding responsibilities.

CCGs and the NHS England should ensure that robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected. This will include contributing fully to Serious Case Reviews (SCRs) which are commissioned by LSCBs/SABs and also, where appropriate, conducting individual management reviews. Health organisations should also consider carefully any requests from an LSCB or SAB for information which is relevant to a SCR.

In addition to the distinct responsibilities that the NHS England has as a commissioner of primary care and other services, it is also responsible for ensuring that the health commissioning system as a whole is working effectively to safeguard and improve the outcomes for children and adults at risk and their families, and thus promotes their welfare. It provides oversight and assurance of CCGs' safeguarding arrangements and supports CCGs in meeting their responsibilities. This includes working with the Care Quality Commission (CQC), professional regulatory bodies and other national partners.'