# WANDSWORTH SAFEGUARDING ADULTS PARTNERSHIP BOARD

# ANNUAL REPORT

# 2013/14

Contents

## 1. Welcome

I'd like to introduce myself as the new independent chair of the Wandsworth Safeguarding Adults Partnership Board and invite you to read this annual report, the seventh of its kind. I arrive at a time when the findings from Winterbourne View are now being embedded into national and local practice, and with the immediate promise of a Care Act which will set the safeguarding of adults at risk on a solid statutory footing in line with the protection of children. I also chair the Children's Safeguarding Board so I bring to my new role not only a prior knowledge of Wandsworth, but I am in the unique position of being an independent person who can help ensure collaboration and learning between the two Boards. A family focussed approach across the local authority and the 'See the Adult, See the Child' strategy launched last year saw two significant changes in approach and I expect to see the fruits of that initiative during my period as Chair.

In the context of impending legislation, structural changes within the NHS in particular, and continuing financial challenges, working together has never been so important. Partly as a result of work that is going on locally, the appreciation and profile of adult safeguarding continues to increase, and the demands being placed on those engaged in this area of work continues to push the boundaries of our capacity to deliver a professional, caring service.

From what I have so far seen I am very encouraged with the response to those demands, and very positive about the contributions to improving people's lives being made by so many people, paid and not paid. As I go about the task of increasing my and everybody's understanding of what is entailed in working with adults at risk, I am acutely aware of how the lives of carers and service users are affected each day by what we do and decisions that we make. So this Annual Report will seek to demonstrate not only how we in Wandsworth have made a difference to those lives over the last year, but how we intend to do so in the years to come. I would like to thank all the staff from all the agencies for their continued contribution to the work of safeguarding adults at risk.

You will find this Annual Report shorter than previous years but we have highlighted where you will be able to access more information. The report is shorter but the central message remains the same – we will impact on people's lives not just by improving processes and procedures, but by listening to how people want to feel and be safer, and by demonstrating that our intervention has enabled that to happen.

I'd welcome your assistance in whatever way you can to make our aims a reality.

**Nicky Pace**
**Independent Chair**
**Wandsworth Safeguarding Adults Partnership Board**

## 2. Who We Are & What We Do

- The Wandsworth Safeguarding Adults Board is made up of all the statutory provider's of care within the borough, as well as those locally and nationally who commission and inspect those services. The Board also has representation from other agencies such as the Police and Probation Services and the voluntary sector. Crucially we have carer and service user input.

- Adult safeguarding is the responsibility of all agencies and cannot exist in isolation. We try to link it effectively to other initiatives as part of a network of measures aimed at enabling all to have a life free from violence, harassment and exploitation. Safeguarding adults is not a social care responsibility alone but a core function for councils, the NHS and the Police. That is why we work together and why service users unable to care for themselves can expect us to adopt measures that will:

  - Protect them as far as possible from avoidable harm
  - Enable them to feel safe and secure
  - Support them to manage risk in the way that they wish
  - Identify potential harm and take preventative measures, and
  - Adopt as much as possible a proportionate and least intrusive response.

- In addition as a Board we recognise that all abuse starts with a sense of differentiation, and that it is often when people become increasingly isolated from family and friends that they become vulnerable to abuse and neglect. The actions of the Board and agencies have to be judged against those two maxims.

- The Board works to a business plan which lays out the Board's strategic aims and these are delivered through four sub-groups. In that way the Board can not only guide the work of the agencies but also ensure that in addition to their own internal management, the agencies can be held to account for their safeguarding work.

Finally, some contact details:

- Communities have a part to play in preventing, detecting and reporting neglect or abuse, so if you wish to discuss a safeguarding concern please contact the Wandsworth Council Access Team on accessteam@wandsworth.gov.uk.

- For a complete list of Board members, contact details, meeting times, policies and procedures, and the Board's action plans please visit our website at safeguardingadults@wandsworth.gov.uk.

- And if you think that you could assist the Board in its work in anyway, please contact the Wandsworth Council Safeguarding Team at safeguardingadults@wandsworth.gov.uk

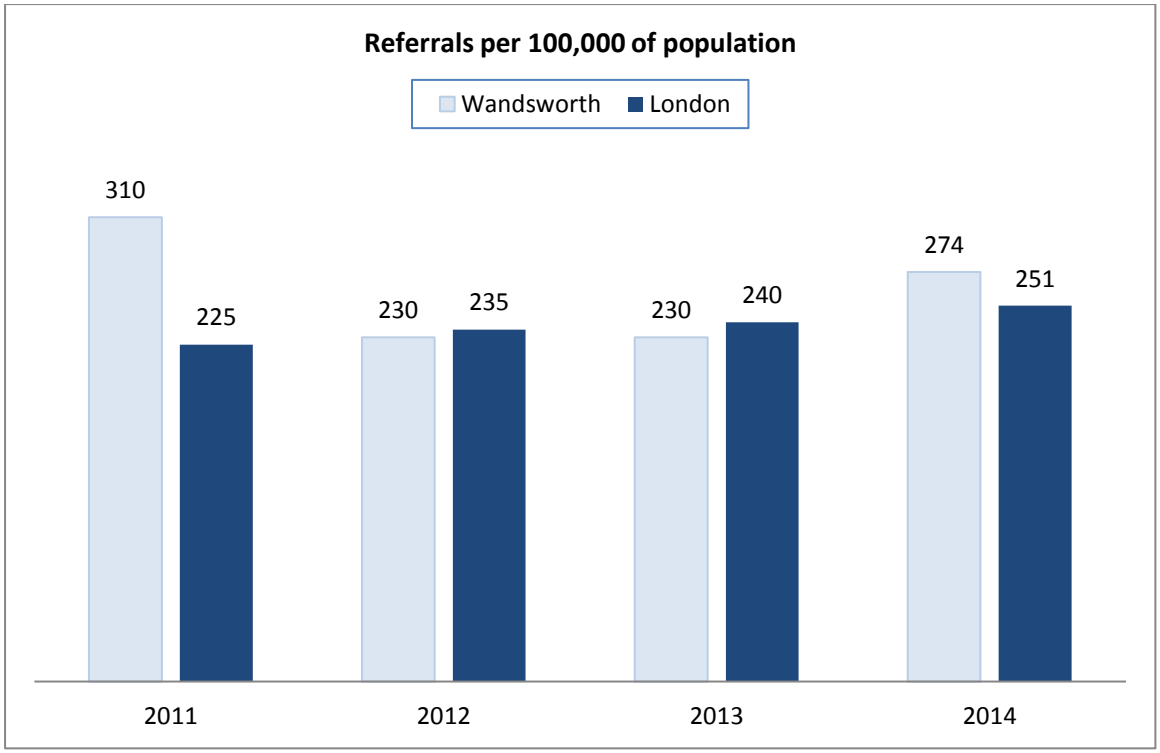
## 3. Safeguarding – In Numbers

- There have been a number of changes in national reporting this year so direct comparisons with last year's figures are problematic in a number of areas e.g. alerts to referrals are no longer recorded because of the discrepancies in the way that authorities defined and recorded alerts; neither is data on protection plans, again making benchmarking impossible. Much of the data has been reported for the first time in a new format and there have been identified discrepancies in the way that different boroughs have interpreted and reported the statistics. This has been acknowledged by the Health & Social Care Information Centre [HSCIC] who are revising the guidance and clarifying the definitions for 2014-15 reporting year. London comparator data used in this report is provisional and subject to change.

- Wandsworth has the largest mental health in-patient setting and specialist mental health resources in London. Therefore safeguarding referrals from mental health settings are higher than other London boroughs and this affects the way data appears when compared with London averages. For example, ethnicity, place of abuse, type of abuse, referrer etc. This factor is identified throughout the report where relevant.

- The current information available to the Board allows it to make comparisons with the activity of other boroughs but less than it would like about the quality of that activity. The Board is intent over the next year on identifying what additional information is needed to supplement the national data to allow it to work effectively in safeguarding adults across the Borough. Workshops are planned for the autumn which will also identify what relevant information from partner agencies should be included in the reports.

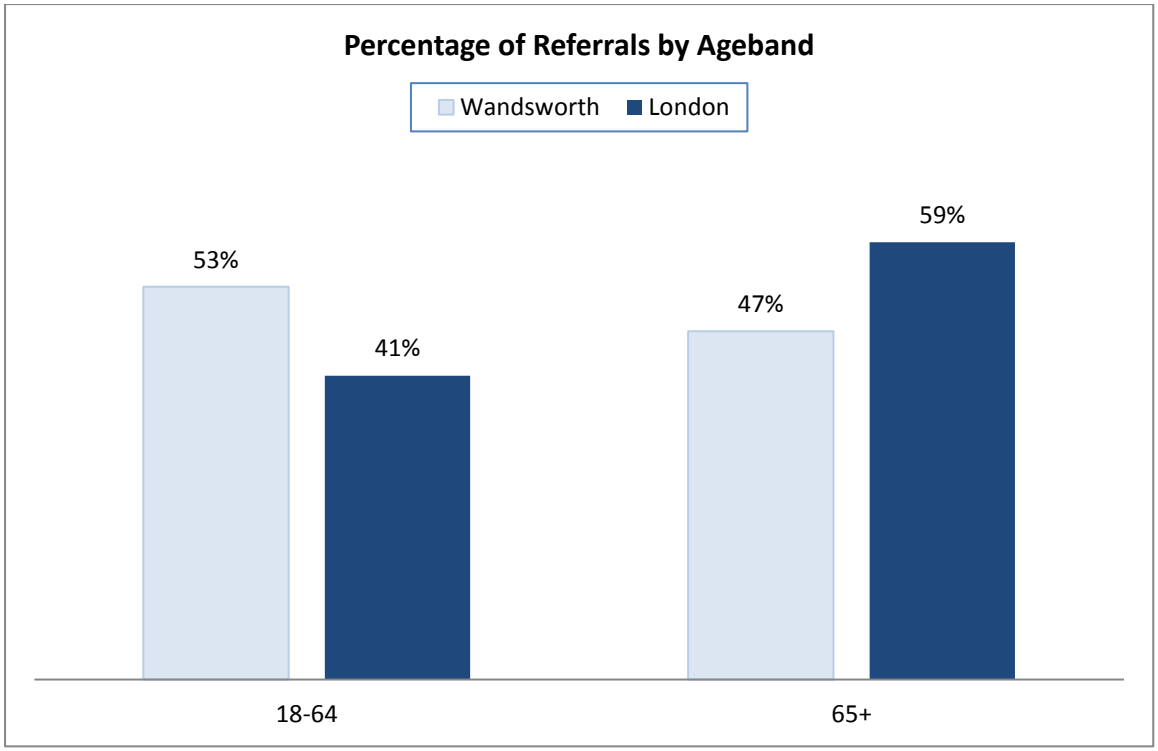
- The main focus for coming months will also be on ensuring better, qualitative information on outcomes which the work on 'making safeguarding personal' will provide.




- Referrals per 100,000 of population continue to rise back to the peak reached in 2011

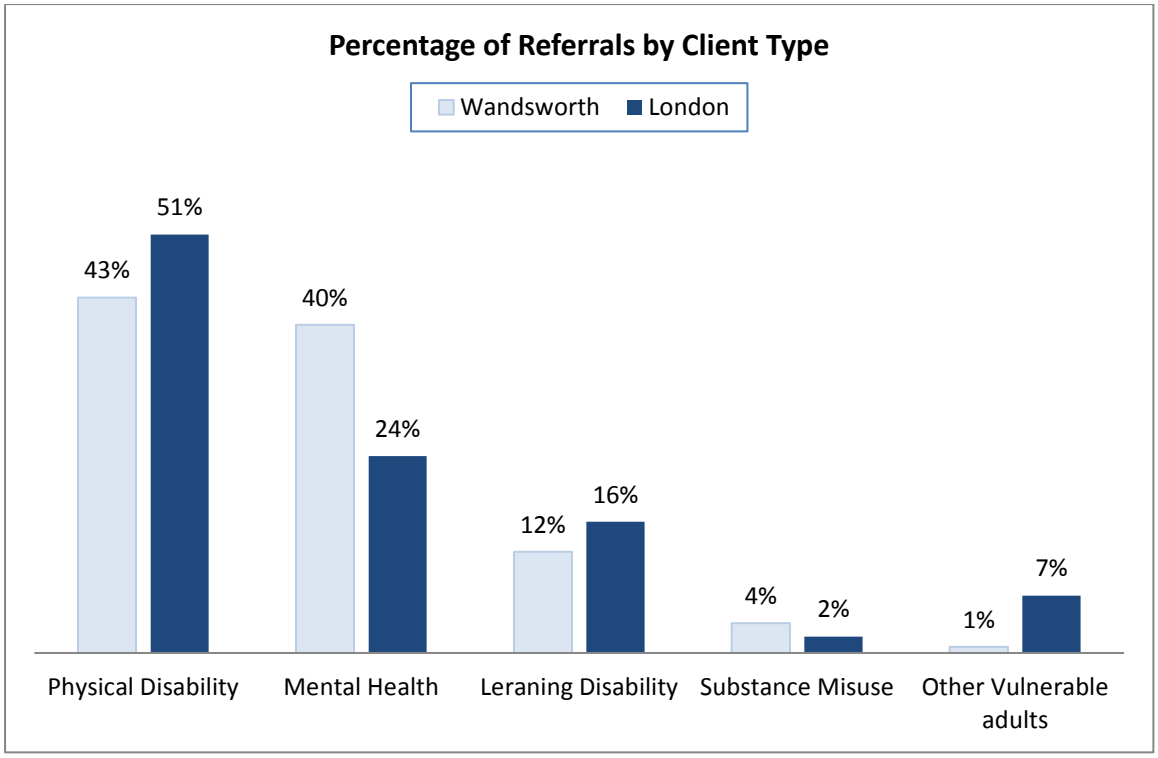
- Compared to the rest of London, referrals in Wandsworth are slightly higher than the average. A recently completed audit of safeguarding referrals suggested that thresholds for reporting and accepting referrals are too low, contributing to the increasing volume of referrals. Further work is proposed to ensure responses are proportionate and that appropriate threshold decisions are maintained.

- National reporting of serious concerns about the quality of care for older people in some residential and nursing homes has continued to increase public awareness and that together with a continued programme of safeguarding training may have contributed to the increased number of referrals.




- Referrals broken down by age band show that a higher number of people aged 18-64 in Wandsworth are subject to a referral and a lower number of over-65's compared with the London average. Over half (55%) of the 18-64 aged referrals are made of people from mental health services reflecting the high concentration of mental health inpatient settings in Wandsworth compared to anywhere in London.

- Wandsworth also has a younger population profile than some of the comparator authorities which explains some of this trend.




- Mental health referrals for Wandsworth are higher than the London average, and consequently there are significant differences in each of the other user groups. The higher rate of mental health referrals is reflective of high concentration of mental health settings in Wandsworth compared with elsewhere in London.

- Compared to last year mental health referrals are ten percentage points higher.  South West London St George's mental health trust have reported that they have seen significant increase in adults at risk using their in-patient settings at Springfield hospital, Queen Mary Hospital and Community rehabilitation hostels..

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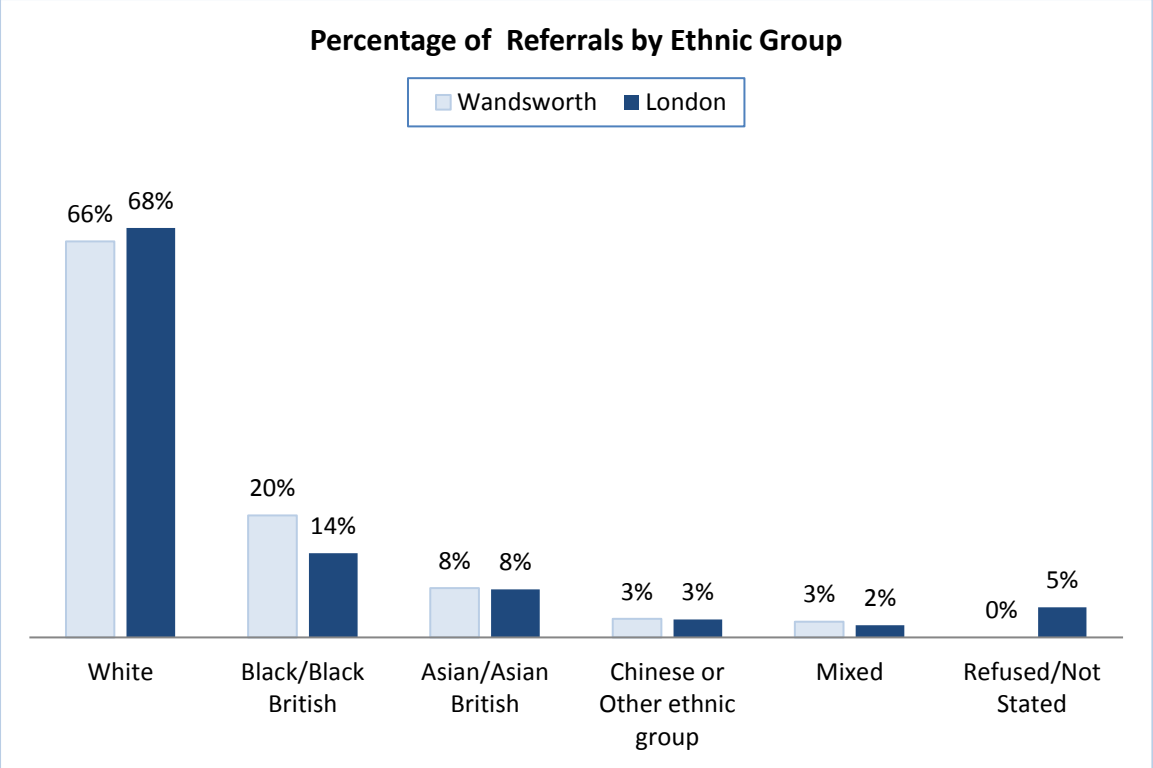
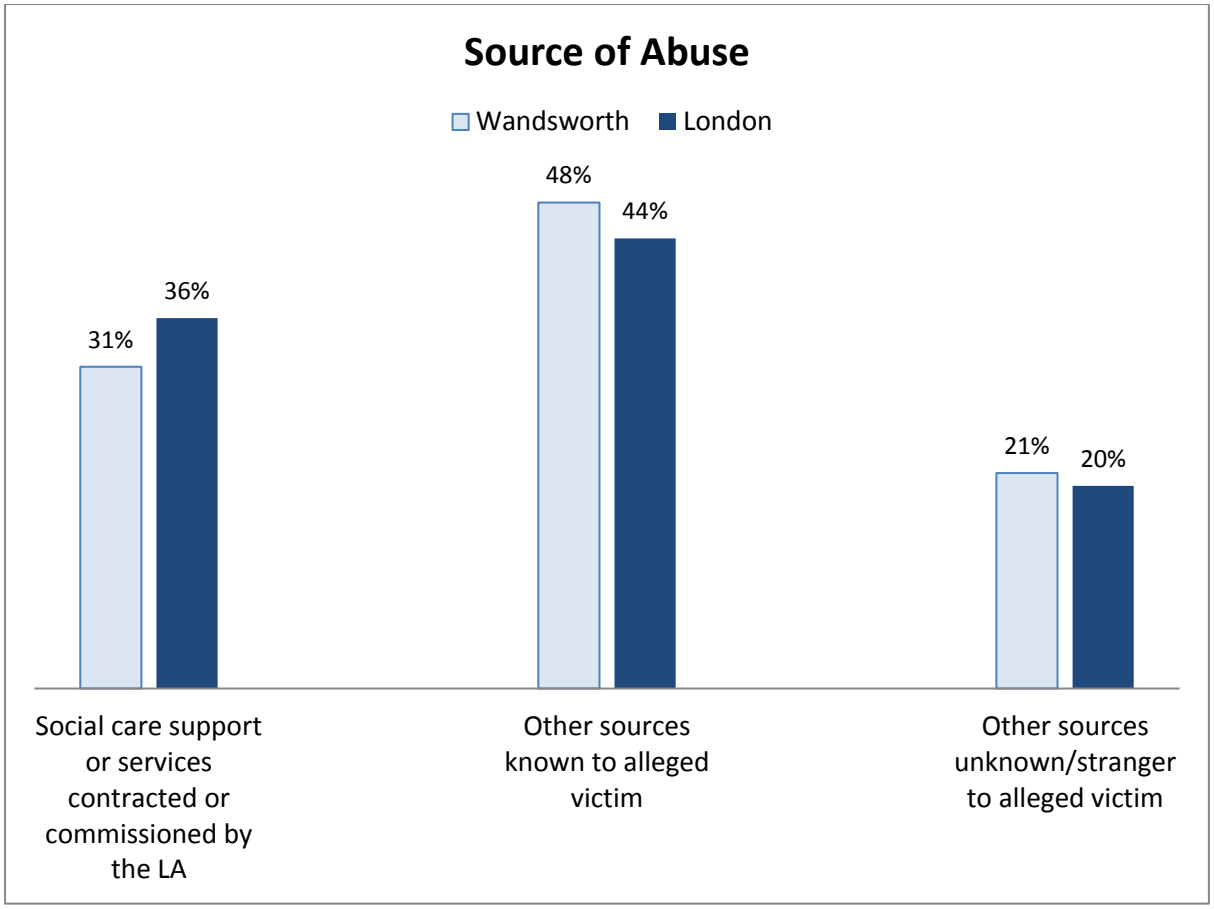
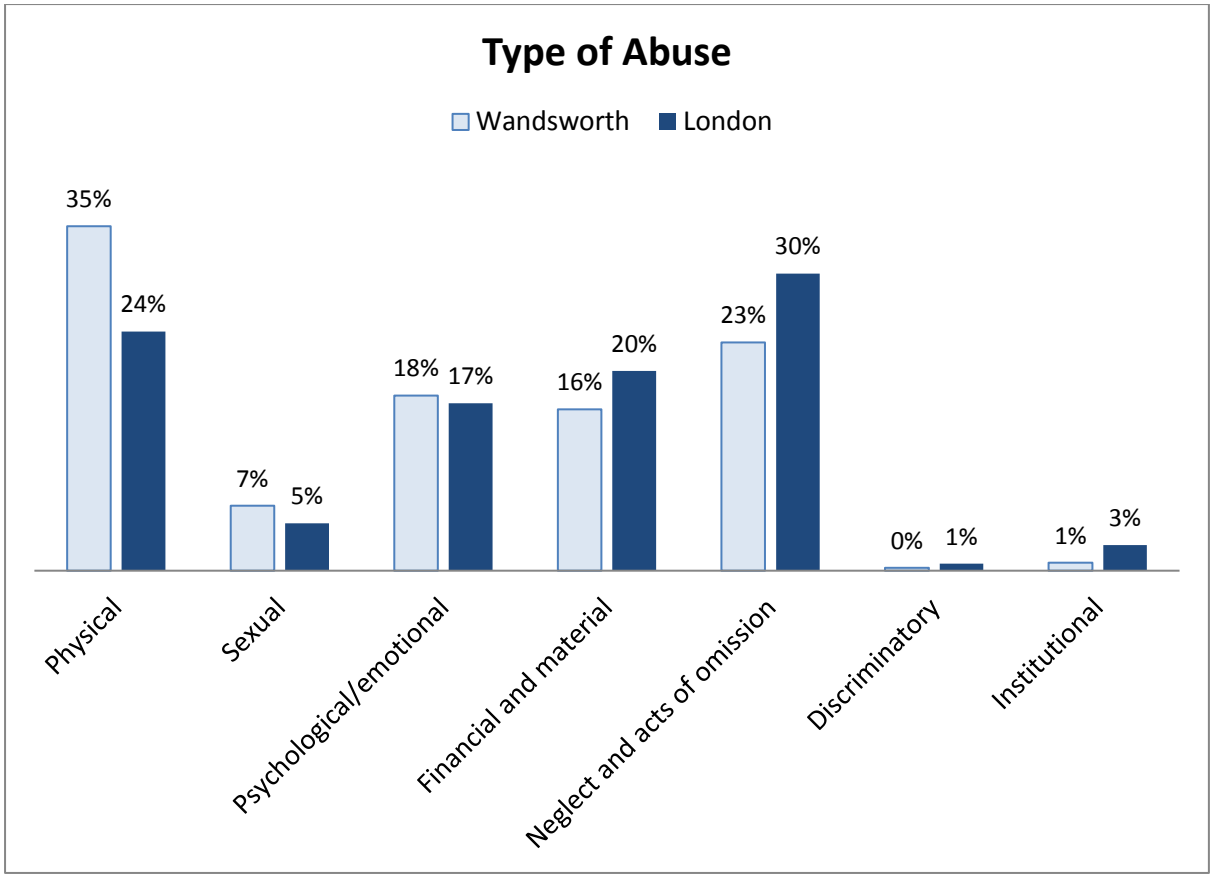



- The comparison with last year's figures for Wandsworth would suggest a slight increase for Black/Black British referrals and a difference with this year's London –wide figure. This may be explained by a higher number of Black/Black British as a proportion of the population than other boroughs and the relatively high number of mental health service users from this ethnic group.



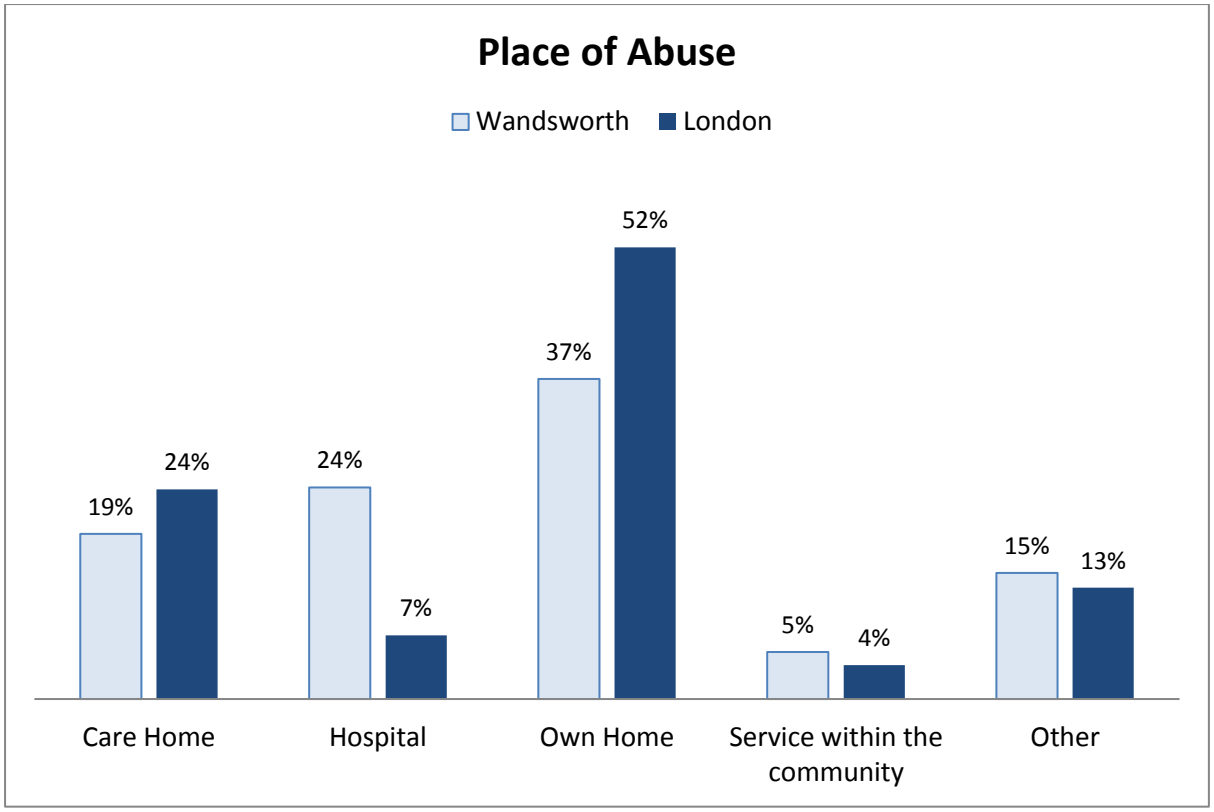

- This year's safeguarding return categorised risk in a different way to previous years. Risk to alleged victims in Wandsworth from unknown/stranger source is broadly similar to London, while risk from sources known to alleged victims and from services commissioned by the LA is slightly higher than London. The significance of this is not immediately explainable and more work will be done through the year to better understand this statistic. Once again this figure may have been influenced by the high number of mental health referrals which have skewed the figures.




- With the exception of physical abuse Wandsworth is broadly in line with the London average

- There has been a swing in the current year to more referrals in regard to neglect (from 16% to 23%) and a commensurate decrease in financial abuse (from 23% to 16%)

- There are no figures this year identifying abuse by gender or age as completed referrals are no longer reported on by gender and ethnicity




- The incidence of abuse in the person's own home remains considerably below the London average, reflecting perhaps the low level of referrals coming from domiciliary care sources. Equally there might be differences in the way that incidents are reported for example, as a safeguarding referral or as a complaint. Work has already begun to analyse what if any action is required.

- The figure in regard to care homes compared with the average gives rise to similar concerns about potential under – reporting. Again, more work is needed to address this problem.

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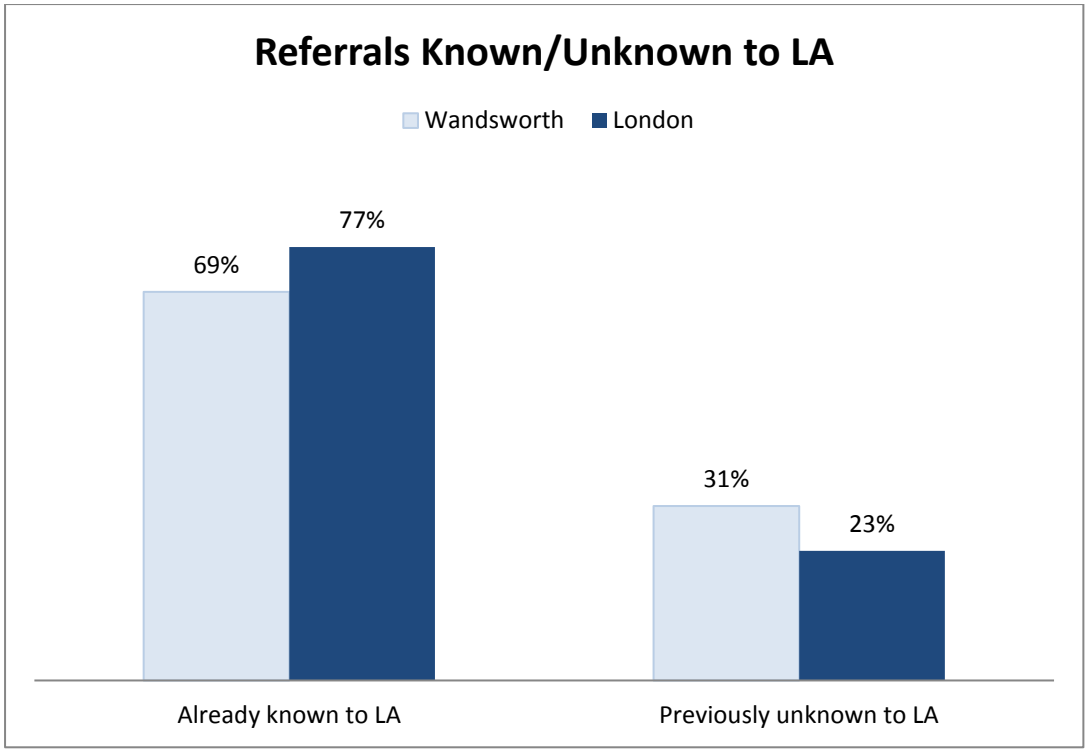
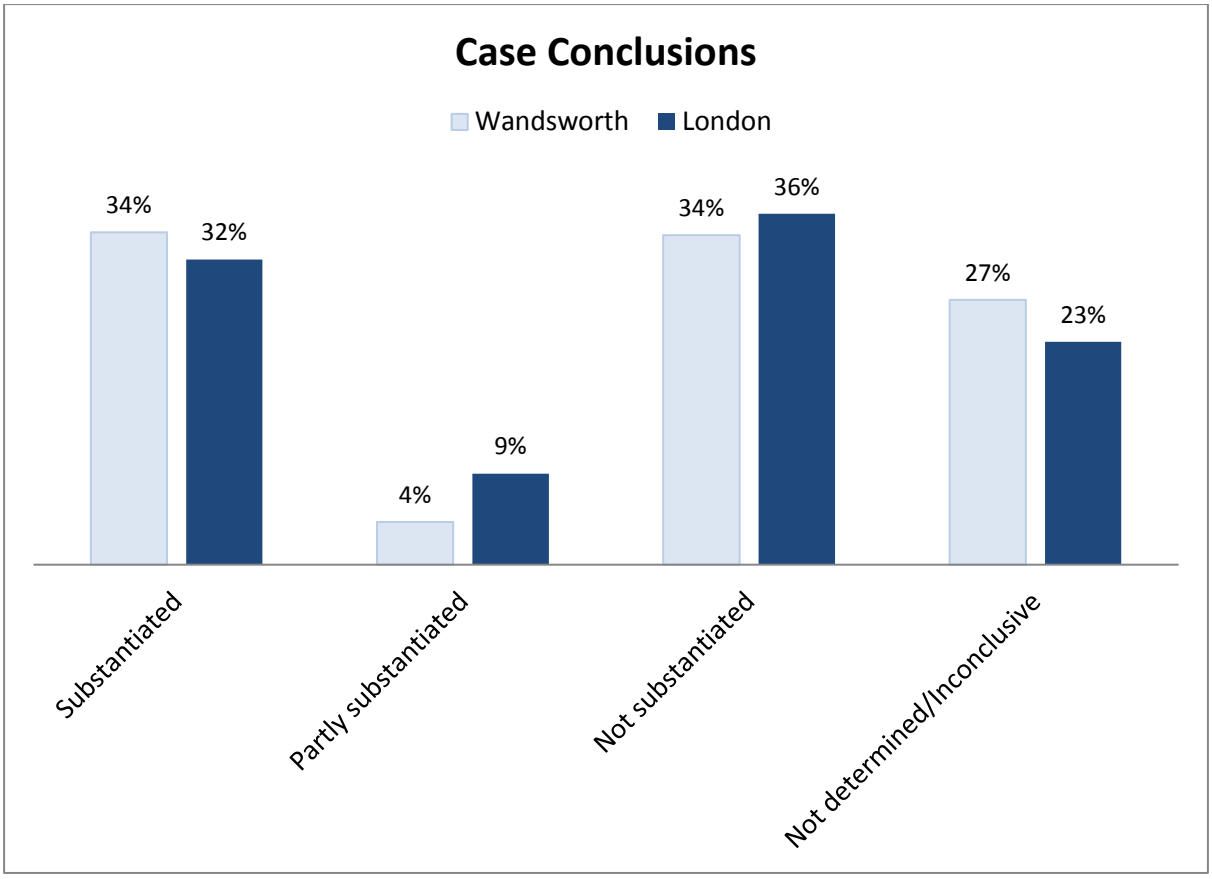
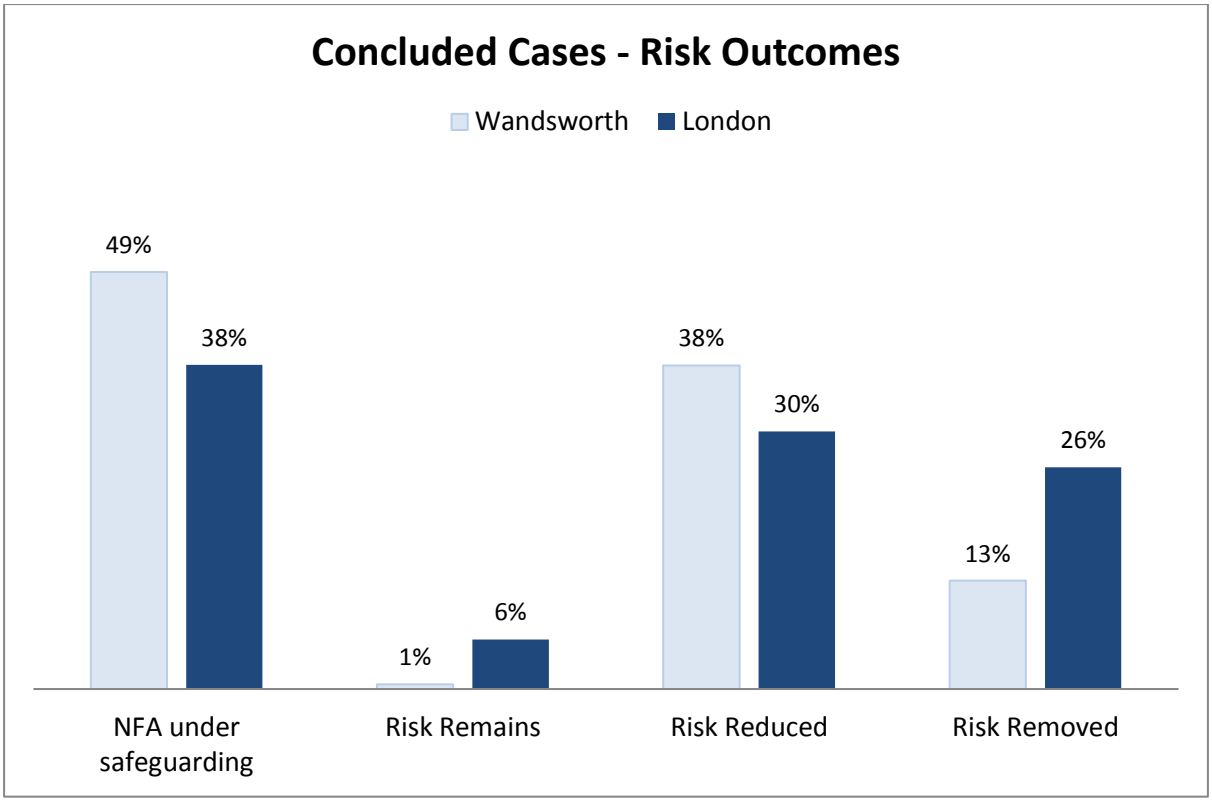



- This is a slight variation compared with last year (66% known and 34% unknown)
- Of the referrals this year 10% were repeat referrals affecting the same service user. Nationally repeat referrals are no longer measured as in previous years.




Percentages may not add up to 100% due to rounding

- Again this repeats the pattern of last year and is broadly in line with the London average. A current review of decisions arising from the thresholds audit which identified a need to tighten decisions on eligibility, may lead to a further increase in substantiated outcomes following recording practice improvements.




Percentages may not add up to 100% due to rounding

- This is a new outcome reported nationally for the first time in 2013/14. High percentage of NFA (no further action) under safeguarding is once again indicative of the low threshold in accepting safeguarding cases. The threshold audit and resulting action plan together with the further guidance that has now been issued to practitioners in interpreting risk should reduce the number of NFAs and support a more proportionate attribution of risk.

## 4. What the Partners Did in 2013/14

St George's Healthcare NHS Trust

- The recent CQC report recognised that through safe and effective practice the Trust was meeting its responsibility under Outcome 7 of CQC regulations to ensure that those adults most at risk are "protected from abuse and that staff should respect their human rights". On the other hand the report noted that we needed to make improvements in staff's understanding and implementation of the Mental Capacity Act.

- The Trust has now established two full time learning disability nurses who provide support and advice to staff, patients and their carers, and we have many examples of how reasonable adjustments can have a positive impact on patients and families experience whilst in hospital. We have put a Butterfly Scheme in place to highlight those with dementia and their specific care needs.

- The Trust has seen a reduction in the development of avoidable grade 3 & 4 pressure ulcers following the employment of two full time tissue viability nurses and increased awareness and reporting of skin breakdown amongst other staff.

- The Trust dealt with a 40% increase in safeguarding referrals (seventy-two in total) while the patient was both in St Georges and in the process of being either admitted or discharged from the hospital. Sixty-two cases were not substantiated; three were found to be inconclusive; and seven substantiated (i.e. 10% compared with almost 20% in the previous year).

- The Trust has changed a number of systems in the wake of substantiated findings particularly around discharge procedures to ensure that lessons do not go unlearned or not acted upon.

Wandsworth Education & Social Services Department

- The Quality Control Panel met monthly during the last year and through monitoring information identified upwards of fifteen care providers where service levels were considered to be unacceptable, and then guided and monitored the efforts of those providers to improve standards to an acceptable level. Only one provider decided to discontinue providing care and the required improvements were evidenced in the rest.

- The council conducted an audit which demonstrated that some professionals are using the safeguarding process as a way to getting assessments completed robustly. It also showed that where complaints (i.e. not strictly safeguarding concerns) had been incorporated, the outcome was very often

different. The audit recommended a list of actions that will be addressed (see later in this report).

- The council signed up to a national 'Making Safeguarding Personal' project to further improve and evidence that practitioners are involving service users in establishing and trying to meet desired safeguarding outcomes. The project is already demonstrating outcomes which not only cover safety, but which also focus on the service user's wishes and on improved well-being.

- A successful safeguarding adult's conference was held in June 2013, with a focus on learning the lessons from Winterbourne View, and evaluation demonstrated a raised awareness of safeguarding issues.

- Joint working with Children's Services was improved, with clear guidance and training on a Think Family approach, which should bring about demonstrable further improvements in outcomes.

<u>All Agencies: Beyond Winterbourne View – Local Joint Plan</u>

- A joint health and social care action plan was introduced to respond to the lessons from the government report about abuse at Winterbourne View, a private hospital near Bristol for people with learning disabilities. This has led to the transfer of most people in long stay hospital settings to community living environments with support.

Amongst other outcomes the agencies have:

- Completed the Learning Disabilities Joint Commissioning Strategy to ensure appropriate local services
- Consulted with forty-four service users and fifteen carers
- Met the target of ensuring no-one was in hospital unnecessarily
- Commissioned residents training and almost completed basic awareness training programmes
- Reviewed the low-level single-service investigations
- Circulated a whistle-blowing policy to all staff
- Reviewed all service-users resident out of the borough
- Developed a CCG Safeguarding Adults Procedure.

<u>The Police</u>

- In April 2013 the Metropolitan Police introduced a new policy that all incidents dealt with by Police involving a vulnerable adult would be recorded on a central database (Merlin). These reports are then passed to the Public Protection Desk (now the Multi-Agency Safeguarding Hub - M.A.S.H.) who conduct research on the subject and identify any safeguarding risks. The report, along with the intelligence and analysis, is then shared with Adult Social Services.

- The main challenge to improve outcomes for adults at risk has been to raise officers' awareness and knowledge of the subject, and so all Wandsworth Borough Police Officers have received mandatory training to help them understand the definition; how to identify a vulnerable adult; and what to do to record their concerns.

- The combination of the new policy and the training has had a significant impact on the number of potentially at-risk being 'flagged-up' to Adult Social Services who can then provide the appropriate support. In 2012/2013 there were twenty-nine reports submitted by Wandsworth Borough Police Officers, but in 2013/2014 there were one-thousand. Within that year there was a 43% increase in the second six-month period over the first - clear evidence of the improved outcomes for at risk adults in the borough.

- An historical issue has been Adult Social Services not having a secure group e-mail address which resulted in the Police being unsure whether referrals were getting through because they had to be forwarded through the Children's Services. This matter has been resolved and we are now able to e-mail all adult at risk reports direct, thus strengthening the whole process.

SWLSTG Mental Health Trust

- An in-depth investigation was co-ordinated by council and Trust staff into allegations of abuse and neglect in a ward in-patient unit, following on from concerns raised by an anonymous whistle- blower. None of the twenty-seven allegations were substantiated. However, as part of the response a comprehensive action plan was implemented by the Trust.

- The Trust Safeguarding Adults Policy was reviewed to ensure alignment with the Pan London policy

- The safeguarding adult's manager (SAM) role has been embedded throughout the Trust and all wards and teams were made aware of the SAM's role in the safeguarding process. Team managers and principal social workers have taken up the role, and provided a focal point for others to refer to. Where cases are managed externally (e.g. Wandsworth Borough Council) it has clarified where the responsibility for a case lies, and for coordinating and leading the investigation.

- The Trust has improved its electronic reporting system so that all staff can now report a safeguarding concern which goes to a manager to action. The systems for recording safeguarding, serious/critical incidents and complaints are being further integrated so that we will have a complete view of the quality of our services, better monitoring by the Trust's safeguarding compliance group, better learning, and better outcomes for service users.

- The Trust held a well-attended learning event on Winterbourne View, and two successful 'Workshops to Raise Awareness of Prevent' (WRAP) were

held with representatives from forensic services, security, CAMHS and directorate leadership.

- The introduction of the Trust's own e-learning package has had significant impact on the numbers of staff trained at Basic Awareness Level 1, rising from 52% to 90% compliance, with a further increase expected to meet the target of 95% in 2014/15.

- An audit was carried out to ensure that the Trust has sound safeguarding processes and mechanisms to mitigate any risks to service users, the results of which are below. The overall 'Reasonable' assurance level was determined because whilst policies and governance was sound, some weaknesses were identified in training compliance as well as the levels of assurances obtained to ensure safeguarding processes are working effectively within the individual boroughs. The following table provides a summary.

| **Control Objective/ Risk Area** | **Assurance Level** | **Recommendations by Priority** | | |
|---|---|---|---|---|
| | | **High** | **Med** | **Low** |
| 1. Policy and procedural guidance to ensure vulnerable adults are safeguarded is comprehensive and has been approved. | Reasonable | | 3 | |
| 2. There is an appropriate governance structure in place. | Significant | | | 1 |
| 3. Adequate training is provided to staff dealing with vulnerable adults. | Limited | 2 | 2 | |
| 4. Established practices are in place to ensure that vulnerable adults can be safeguarded. | Reasonable | 1 | 3 | |
| **Overall Assessment** | **Reasonable** | **3** | **8** | **1** |

Wandsworth Housing Department

- The department provided refresher safeguarding adults and children training to two hundred and four members of staff covering the majority of frontline workers, and which included different safeguarding scenarios.

- The department also produced an updated safeguarding adults briefing note, pack and letter which was distributed to Bed & Breakfast accommodation providing a service on behalf of the department.

- A safeguarding adults and children article was published in the December 2013 edition of Homelife (The Housing Department's newsletter), and all floors and main reception areas displayed the most up- to- date safeguarding posters.

Wandsworth Clinical Commissioning Group (WCCG)

- In November 2013 a substantive Safeguarding Nurse Lead was appointed which will improve continuity and consistency and provide better assurance to the Board.

- WCCG has recognised its role in ensuring Deprivation of Liberty issues are addressed within its commissioned services, and as a result two WCCG nurses are in the process of completing the Best Interest Assessor training.

- A Nursing Home forum, once convened by the local authority, has been re-established with Wandsworth's fourteen nursing homes on a quarterly basis. The forum addresses safeguarding issues and allows the home managers to share best practice.

- A number of providers in 2013 were identified as having service level concerns and WCCG has led clinically in formulating action plans with providers to improve standards and reduce safeguarding concerns e.g. by carrying out medical audits, appointing independent investigators, and participating in 'turn- around' teams.

## 5. What the Board Did in 2013/14: A Snapshot of Key Progress

Performance & Monitoring Sub-group

- The audit cycle was reviewed and plans are being developed to ensure audit can be utilised by each agency to provide the necessary reassurance around adults at risk and safeguarding.

Training & Publicity Sub-group

- A training plan was adopted to ensure continued improvement in the skills and knowledge of paid and unpaid staff across agencies.
- Improved monitoring of training attendance was adopted to ensure that all staff are covered by appropriate levels of training.

Policy & Procedures Sub-group

- A Police Engagement protocol was adopted.
- Policy and procedures were reviewed and the foundation of CCG safeguarding procedure was established.
- Making Safeguarding Personal arrangements were put in place by the council and shared with partner agencies.

Publicity Sub-Group

- A successful safeguarding conference, and arrangements for the dissemination of awareness material during safeguarding week in June, were both planned by this sub-group.

Safeguarding Adults and Children's Sub-Group

- This sub-group was established to ensure effective joint working by partner agencies across both service areas.
- A 'See the Adult, See the Child' joint protocol was developed to further improve reporting and joint working.
- Training on the 'Think Family' strategy was put in place.

## 6. Challenges & Opportunities in 2014/15

On top of the perennial challenges such as growing referral rates, the implementation of new legislation and financial challenges, this year will see two new challenges – and opportunities - for the safeguarding agenda and which will help shape the work programme over the next three years.

## Deprivation of Liberty

- The Wandsworth Safeguarding Adults Team continues to be responsible for the coordination and development of Deprivation of Liberty Safeguards (DOLS). Following a Supreme Court judgement in March 2014 a clearer definition has emerged which provides a new test for those safeguards but which has huge implications for local authorities and providers alike.

- The court clarified that a deprivation of liberty exists when a person is under continuous supervision and control and is not free to leave, and when that person lacks the capacity to consent to these arrangements.

- The court also held that a deprivation of liberty can occur in domestic settings where the state is responsible for imposing such arrangements. This could now include a person living in the community in supported living or extra-care sheltered housing, and in such cases those arrangements must be authorised by the Court of Protection.

- This new test has resulted in a significant national increase in the number of people who now fall within the DOLS definition and that increase has inevitably been reflected in Wandsworth. The number of referrals in 2013-14 was thirty-seven; however, in the four months since April 2014 that has increased to one hundred and twenty-four.

- It is difficult to predict future demand however, work is going on locally and nationally to match the need to safeguard people on the one hand and resources on the other. In the meantime, the local authority has plans to increase the number of staff trained to undertake the work and achieve efficiencies where possible.

## The Care Act 2014

- The Care Act 2014 became law in May this year and will be fully implemented in 2015. It sets out for the first time a statutory framework for adult safeguarding, and Safeguarding Adults Boards acquire powers in line with those that have been in force for many years in work protecting children. That will not require great change in Wandsworth, because much of what will be required we have already been doing as ‘best practice’.

- Boards may now do ‘anything which appears to it to be necessary or desirable for the purpose of achieving its objective’. Wandsworth Council, the local Clinical Commissioning Group and the Police *must* be represented on the Board along with any other group that the council deems appropriate. And the Board *must* produce an annual report (increasing its public accountability).

- Where an adult considered vulnerable dies, a Serious Case Review of how that happened *must* be carried out, and this extends to an adult at risk suffering a serious injury or neglect if one of the Board's partner's is involved.

- Importantly, if the Board asks for information to aid its investigation that person or organisation *must* comply. And if no-one else is available the adult at risk must have an independent advocate.

- The council now has a duty to carry out enquiries or cause others to where it thinks that an adult is at risk of abuse, and it also now has a duty to safeguard the moveable property of people who go into hospital or care where no suitable arrangements have been made and where the LA is meeting the care costs.

- As with the DOLS work (above) it is hard to predict the impact of these additional responsibilities on resources.

## 7. What The Partners Will Do in 2014/15: A Snapshot

- At St George's NHS Trust we recognise that mental capacity can have a significant impact on a patient's on-going care plan and discharge planning. The complexities of balancing risk with respecting patient's wishes can present significant challenges to families/carers and professionals alike and these cases can often involve a significant impact on time and resources to ensure an effective discharge. Our priority for the coming year will be to address the inconsistent approach and understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards across the Trust.

- To ensure that safeguarding remains high on St George's Trust agenda, it will begin to present monthly updates on safeguarding outcomes to the Trust Board as part of our regular quality performance programme.

- The local authority Quality Control Panel will improve its management information on safeguarding incidents involving domiciliary acre agencies

- Within the context of the Local Joint Plan, consideration will be given to establishing a joint Care Home Support Team to support failing institutions; and the establishment of link workers in particular hospital wards.

- Wandsworth Council will address the issues identified in the March 2014 audit of thresholds, including improved arrangements for Making Safeguarding Personal, improved performance information linked to strengthened triage and management oversight, peer review and practice workshops, and improved referral threshold decisions guidance.

- The main priority for the Police is to continue to raise awareness regarding safeguarding adults at risk which is to include 'disability hate crime' and for adults at risk to be incorporated into the whole MASH process.

## 8. What the Board Will Do in 2014/15: A Snapshot

The Board's strategic priorities are based on the principles outlined earlier in this report:

- Agreeing what information the Board needs so that it can better ensure the effectiveness of what each of its members does (See strategic improvement plan: sections 1 and 4).

- Continuing to develop the personalisation of safeguarding and promoting independent living through improving preventative services (See strategic improvement plan: section 2).

- Improving service quality in residential and other supported living schemes (See strategic improvement plan: section 3).

- Regular agency audits developing a strategic view of where risks are and a structured view of how to respond to them (See strategic improvement plan: section 4).

- Providing staff across all agencies with updated training to ensure sufficient knowledge and skills to effectively safeguard adults from abuse, and ensuring service users are aware of good quality care and how to report abuse (See strategic improvement plan: section 5).

- Providing updated information to the public on awareness and reporting of suspected abuse (See strategic improvement plan: section 5).

## 9. DRAFT SAPB STRATEGIC IMPROVEMENT PLAN 2014-17

**Aim: The SAPB is committed to safeguarding vulnerable adults at risk of or suffering abuse, and enabling retention of independence, well-being, dignity and choice.**

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
|---|---|---|---|---|---|---|
| 1. | The Safeguarding Adults Partnership Board (SAPB) will ensure effective safeguarding arrangements are in place to safeguard adults at risk from abuse, and to promote personalisation and well-being, in accordance with the Care Act 2014; will share relevant information; and will hold members to account | Review SAPB information sharing protocol<br><br>Review SAPB membership<br><br>**WSAPB should develop a Strategic Multi-Agency Framework, with senior management commitment to facilitating multi-agency collaboration, (pooled?) resources and structure for managing Adult at Risk cases that don't fit mainstream service provision, and strategies for service withdrawal. For example: Adopt a Community MARAC model to develop** | Approval and monitoring by SAPB<br><br>SAPB decision | Nicky Pace, SAPB Chair<br><br>Nicky Pace, SAPB Chair | April 2015<br><br>April 2015 | Joint Governance Partnership Protocol presented to SAPB on 29/07/14 |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
|---|---|---|---|---|---|---|
| | | **new pathways and/or commission specialist services to prevent or mitigate personal risk.** | | | | |
| 2. | The SAPB will ensure that good practice and compliance are embedded in safeguarding enquiries, in accordance with the 6 Care Act 2014 principles of empowerment, prevention, proportionality, protection, partnership and accountability | Review pan-London and Wandsworth safeguarding adults policy and procedures to meet the requirements of the Care Act 2014, including threshold decisions and range of responses – participation in DoH consultation | Presentation and report to SAB | Clive Simmons; reporting to Policy and Procedures Sub-Group/SAPB | July 2014 and April 2015 | Presentation to SAPB and workshop on 29/07/14;Safeguarding Adults Policy and Development Manager contributing to London Safeguarding Adults Network working group |
| | | Review approach to Making Safeguarding Personal to ensure that personalised decision making is core multi-agency practice | Half yearly report to SAPB | Kerry Stevens, Clive Simmons; reporting to SAPB | April 2015 | ESSD review on 28 July 2014; to discuss implications on partner agencies |
| | | Review approach to carers involvement in safeguarding enquiries and | Report to SAPB | Kerry Stevens, Eglionna Treanor, Clive Simmons; reporting to SAPB | April 2015 | Carers workshop completed; further to be arranged |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
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| | | consultation | | | | |
| | | Implementation of DESS Thresholds Audit Action Plan | Half-yearly report to SAPB | Kerry Stevens, Clive Simmons; reporting to SAPB | April 2015 | Action plan drawn up and implementation underway |
| | | Consider development of an integrated or adults Multi Agency Safeguarding Hub (MASH) | Report on proposal to SAPB | Kerry Stevens, Clive Simmons; reporting to SAPB | April 2015 | SA Policy and Development Manager participation in London Safeguarding Adults Network (LSAN) MASH working group |
| | | Development of *Think Family* approach with introduction and monitoring of joint assessments | Half-yearly report to SAPB | Kerry Stevens, Linde Webber, Clive Simmons; reporting to SAPB | April 2015 | See the Adult, See the Child joint protocol in place; developing performance information and training |
| | | Review and monitor application of Mental Capacity Act, and involvement of advocacy, in safeguarding | Report to SAPB | Kerry Stevens, Clive Simmons; reporting to SAPB | April 2015 | |
| | | Meet increased Deprivation of Liberty Safeguards (DoLS) workload arising from the Cheshire West | Half-yearly report to SAPB | Kerry Stevens, Clive Simmons; reporting to SAPB | April 2015 | Increased referrals managed to date |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
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| | | supreme court ruling<br><br>Review Police Investigation Protocol to ensure robust and consistent<br><br>Implementation of Clinical Commissioning Group (CCG) safeguarding adults procedure to ensure consistent approach to screening and investigations<br><br>Review and update Safeguarding Adults (formerly Serious Case) Reviews procedure in line with Care act 2014<br><br>**Develop inter-agency Protocols to support Community MARAC recommendation. These should include agency escalation/non-** | <br><br>Updated protocol To SAPB<br><br>Procedure to SAPB<br><br>Report to SAPB | Jim Foley, Clive Simmons; reporting to Policy and Procedures Sub-Group/SAPB<br><br>David Parry, Clive Simmons; reporting to Policy and Procedures Sub-Group/SAPB<br><br>Clive Simmons; reporting to Policy and Procedures Sub-Group/SAPB | October 2014<br><br>October 2014<br><br>April 2015 | Draft completed |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
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| | | **compliance channels (e.g. unilateral withdrawal of service).**<br>**b) Develop policy and procedures to enable implementation of (a). For example: development of the VARMM with specific underpinning structure, standards, roles and responsibilities, similar to the Safeguarding Adults process and prioritisation expectations.**<br>**c) Undertake an objective review of all WSAPB partner Safeguarding Policy and Procedures to ensure they are fit for purpose i.e. complement and explain how the WSAPB Policy & Procedures** | | | | |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
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| | | **(including VARMM) are applied within** | | | | |
| 3. | The SAPB will ensure that service users with learning disabilities in long-stay hospitals are able to move to more independent community settings, wherever possible; the continuous improvement of service provider quality standards across service user groups and settings to prevent abuse; and a robust and proportionate response to service level concerns (concerns about quality standards in care provision) | Monitoring of Beyond Winterbourne View action plan concerning transfer of service users with learning disabilities from registered hospitals to community settings<br><br>Further development of multi-agency Quality Control Panel to monitor and address service provider quality standards<br><br>Review Service Level Concerns and embargo protocols to ensure robust and consistent approach<br><br>Review contractual requirements of service providers in relation to quality | Half-yearly report to SAPB<br><br>Half-yearly report to SAPB<br><br>Updated protocol to SAPB<br><br>Feedback to SAPB | Mike Abel; reporting to SAPB<br><br>LA, CCG and Mental Health Commissioning; reporting to SAPB<br><br>Clive Simmons, LA, CCG and Mental Health Commissioning; reporting to SAPB<br><br>LA, CCG and Mental Health Commissioning; reporting to SAPB | April 2015<br><br>April 2015<br><br>April 2015<br><br>April 2015 | Register of service users completed and number of residents in registered hospitals reduced to 7, with further progress to 4 people planned by October 2014<br><br>Quality Control Panel meets monthly<br><br>Multi-agency protocol in place |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
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| | | standards and safeguarding, including whistle blowing<br><br>Consideration of feasibility of developing a Care Home Support Team, involving health and some social care, to prevent and respond to service level concerns | Feedback to SAPB | Clive Simmons, LA and CCG Commissioning; reporting to SAPB | April 2015 | |
| 4. | The SAPB will receive evidence and assurance from members that borough residents are safeguarded from abuse; that regular auditing, and learning from audits about trends and risks, is completed within member agencies | Development of multi-agency information dashboard with agreed relevant information<br><br>Development of multi-agency audit along lines of safeguarding children section 11 audit<br><br>Further develop and align individual agencies audit | Report to SAB on proposal, following SAB discussion; half-yearly report to SAB<br><br>Report to SAPB<br><br>Half-yearly report to SAPB | David Flood, Clive Simmons; reporting to Performance and Monitoring Sub-Group/SAPB<br><br>David Flood, Clive Simmons, Linde Webber; reporting to Performance and Monitoring Sub-Group/SAPB<br><br>David Flood, Clive Simmons; reporting to Performance and Monitoring Sub- | April 2015<br><br>April 2015<br><br>April 2015 | Workshop at SAPB to be held in October 2014<br><br>ESSD audit programme in place – operational and commissioned external |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
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| | | programme<br><br>**Develop a Quality Assurance Framework to monitor effectiveness of risk management and outcomes at case, service and agency level for all VARMM cases, including case file audits, and reporting to WSAPB.**<br><br>**Ensure robust agency risk management systems feed into**<br><br>**Develop a WSAPB Serious Case Review Action Plan to implement the recommendations, with regular monitoring (multi-agency and individual agency).**<br><br>**Evaluate outcomes to determine: If someone with** | | Group/SAPB | | |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
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| | | **similar complex needs and challenging behaviours presented, would there be a more positive outcome** | | | | |
| 5. | The SAPB will ensure a knowledgeable and skilled workforce across agencies in recognising and responding to abuse, and empowered service users in enabling improvement of poor standards and tackling abuse; leading to personalised and positive outcomes for service users; that all sectors and sections of the community are informed about what abuse is and how to report it | Further develop and monitor/evaluate multi-agency safeguarding adults training plan, covering staff and residents<br><br>Monitor attendance at safeguarding adults training to ensure coverage<br><br>Plan further themed bi-annual Wandsworth safeguarding adults conferences<br><br>Further improve safeguarding adults website information | Annual training plan endorsed by SAPB<br><br>Half-yearly report to SAPB<br><br>Report to SAPB for approval<br><br>Report to SAPB | Sandra Storey, Mark Barnard, Clive Simmons; reporting to Training and Publicity Sub-Group/SAPB<br><br>Sandra Storey, Mark Barnard, Clive Simmons; reporting to Training and Publicity Sub-Group/SAPB<br><br>Clive Simmons, Mark Barnard; reporting to Training and Publicity Sub-Group/SAPB<br><br>Mark Barnard, Clive Simmons; reporting to Training and | April 2015<br><br>April 2015<br><br>June 2015<br><br>April 2015 | Training plan in place for 2014-15<br><br>Monitoring currently in place by ESSD; developing multi-agency |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
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| | | Develop regular safeguarding adults features in local newsletter<br><br>**Develop a programme of Multi-agency and individual agency learning events to share the learning from YF's case to mitigate potential risk in similar cases.**<br><br>**Develop a programme of training to support acquisition or refreshing of skills to promote best practice in managing risk, chaotic and challenging behaviours.** | Copies of features to SAPB | Publicity Sub-Group/SAPB<br><br>Mark Barnard, Clive Simmons; reporting to Training and Publicity Sub-Group/SAPB | April 2015 | |
| **6. Information Sharing,** | **a)Explore adoption of the Adult MASH model** | **Undertake a review for development of** | | | | |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
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| **Communications & Recording** | **in Wandsworth to facilitate early 'intelligence' sharing for rapid prevention, safeguarding and pathway identification, including identification of patterns of behaviour that may indicate the need for collaborative multi-agency intervention.** | **appropriate access to electronic information systems (e.g. RiO, MPS network,NHS, EMIS) and standards for consistency in use (e.g. to support an Adult MASH, out of hours workers, GP's), to enable better information-sharing and support the Care Act obligations.**<br><br>**Develop clear standards for methods of Communication in Safeguarding and VARMM cases ensuring prioritising of 2-way contact (direct person to person telephone calls and meetings) time-standards, with clarity about role and responsibilities, and duty to share** | | | | |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
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| | | **information, decisions/case guidance etc. at the appropriate seniority level.**<br>**c) Review and develop appropriate quality and time standards for recording Safeguarding and VARMM cases, including cross referral of case-notes, minutes of meetings and assessment documentation, to ensure can effectively respond to risk related developments such as withdrawal of service.** | | | | |
| 7. **Practice** | **Develop practice guidelines to support multi-agency person-centred, preventative and outcome focussed risk** | **This might include screening and 'Best Fit' criteria for multi-agency discussion of long term risk management** | | | | |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
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| | **management.** | **pathways and pooled commissioning. It should include responsibility to identify patterns of behaviour that might require collaborative approaches to person-centred risk management of chaotic or challenging behaviours, and how to escalate concerns, including withdrawal of service.**<br><br>**Explore multiagency agreement to a shared risk assessment tool for consistency. Guidelines should require time specific whole case (Root and Branch) overview and outcome review for future planning.**<br><br>**Develop clear** | | | | |

| No. | Objectives | Work Stream | Evidence | Responsible Group | Timeframe | Progress |
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| | | **role/remit for agency lead staff for VARMM procedures and commitment to inter-agency liaison.**<br><br>**Raise multi-agency awareness of Mental Capacity Assessments** | | | | |
| | | | | | | |