Wandsworth

Safeguarding Adults

Partnership Board

Annual Report 2012-13

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FOREWORD

There can be no secrets and no hiding place when it comes to exposing the abuse of vulnerable adults (DOH/Home Office, No Secrets, 2000).

This is the sixth Annual Report produced by the Wandsworth Safeguarding Adults Partnership Board. It summarises progress against the Safeguarding Adults Partnership Board Work Plan 2011-14, which will be subject to review and renamed the Strategic Plan in the new reporting year.

It has been a year of challenge and achievement for the Safeguarding Adults Partnership Board in working towards a shared vision:

The Wandsworth Safeguarding Adults Partnership Board is committed to safeguarding adults at risk of or experiencing abuse. It is a commitment to preventing adult abuse and to safeguarding interventions that lead to prompt, safe, just, proportionate and person-centred outcomes for adults at risk and their carers.

The Care and Support Bill 2013 is currently progressing through the legislative process and will have a significant effect on the status of Safeguarding Adults Partnership Boards and the profile of safeguarding adults. The anticipated legislation will place Boards on a statutory footing with designated duties and powers, including duties to work in partnership, to complete local authority led safeguarding enquiries and to complete safeguarding adults reviews. The Wandsworth Board has met this challenge by commissioning an independent review of the effectiveness of the Board in performing its strategic functions. Whilst this was an overall positive review, there were recommendations for improvement and progress in meeting these is covered in this report.

A change in primary health care has been heralded by the replacement of Primary Care Trusts with Clinical Commissioning Groups from April 2013. This will extend the responsibilities of local authorities in managing Deprivation of Liberty Safeguards under the Mental Capacity Act 2005. The Wandsworth Board has taken measures to adapt to this change, which are covered in this report.

The need for legislation and an increased profile for safeguarding adults are reinforced by two national scandals involving serious institutional abuse and poor standards. These come five years after the *UK Study of Adult Abuse and Neglect of Older People 2007* found that approximately four per cent of older people living at home are abused and that a majority of those who had reported abuse felt that they were not listened to. In the aftermath of abuse at the Winterbourne View private hospital for people with learning disabilities, the Department of Health published a final report in December 2012 with a programme of national and local actions to be adopted by Primary Care

Trusts and Social Services Departments. The Wandsworth Board endorsed a local *Beyond Winterbourne View – Joint Local Plan* in January 2013 and progress is covered in this report.

Further to this, the Francis Inquiry Report was published in February 2013, highlighting appalling standards of hospital care within the Mid-Staffordshire NHS Foundation Trust. The report recommended a move to *a common culture of putting the patient first*, developing a set of fundamental standards agreed by all, evidence based compliance with these standards, openness and transparency about matters of concern, and improved regulation and accountability. In addition to the aforementioned response to Winterbourne, the Wandsworth Board has seen the implementation of the Professional and Service Standards Framework and the Quality Control Panel, designed to set and monitor expected standards of care and safety across agencies, and progress with this initiative is also covered in this report.

Building on the success of previous years, the Wandsworth Board will strive to meet these challenges in the year ahead, with the setting of new strategic priorities which will be outlined in this report.

Cathy Kerr
Chair
Wandsworth Safeguarding Adults Partnership Board

Dawn Warwick
Director
Wandsworth Adult Social Services Department

1st October 2013

1. STRATEGIC PLAN – REVIEW OF PROGRESS 2012-13

1.1 A Year in Review

The following are key achievements of the Safeguarding Adults Partnership Board in the reporting year, which will be described more fully in the remainder of this section of the report:

- Review of the strategic effectiveness of the Board and implementation of the Audit Action Plan
- Positive audit of the Safeguarding Adults Team and review of the role of the team through an Operational Plan
- Progress against the *Beyond Winterbourne View Joint Local Plan* in promoting local community provision, including reviews and joint working towards transfer to community settings
- Development of the Professional and Service Standards Framework and the Quality Control Panel, with service provider safeguarding activity monitored
- Development of the Safeguarding Adults and Children's Sub-Committee and progress with joint procedure and training
- Review and improvement of the Frameworki recording and reporting system for safeguarding within Adult Social Services
- Coordination of service level concerns meetings in nursing homes and mental health inpatient wards, with evidence of service improvements
- Expanded training plan, including targeted training of senior staff in care and nursing homes and improved management oversight of training attendance
- Review and strengthening of the Police Engagement Protocol, with improved emphasis on evidence from criminal investigations in safeguarding meetings.

1.2 Collaborative leadership

Perspectives of key agency safeguarding leads

The strategic safeguarding adults leads in the Clinical Commissioning Group, South West London and St George's NHS Trust, St George's NHS Trust, Police and Housing have summarised the development of safeguarding adults within each partner organisation during the reporting year, with priorities to take forward, as follows:

Evonne Harding – Adult Safeguarding Lead, Wandsworth Clinical Commissioning Group (CCG)

In April 2013, Wandsworth Clinical Commissioning Group officially became responsible for commissioning healthcare services to the local residents, commensurate with the vision for 'Better care and a healthier future for Wandsworth,' taking strides to establish new services and improve care for patients across the borough.

The CCG is committed to preventing and reducing the risk of abuse and neglect to adults. Safeguarding is an integral part of the CCG's objective of continuing to improve safeguarding practices in Wandsworth. Some continued key areas of focus for the CCG are around:

- Increasing awareness of key issues for vulnerable adults, including increasing the number of referrals involving adults at risk

- Close partnership working with Wandsworth Borough Council through the Safeguarding Adults Partnership Board, Continuing Care, Mental Health, Learning Disabilities, Safeguarding Children Leads and other partner agencies at strategic and operational levels

- Continued development of professional leadership and expertise roles and responsibilities for safeguarding adults and of the CCG's Safeguarding Committee. The safeguarding Committee conducts an annual review of the committee's effectiveness and comments on this in the CCG annual report

- Emphasis on education, training and audit. Safeguarding Adults audits are the norm and help to inform daily clinical practice, i.e. Tissue Viability Audit, and provide self-assurance regarding the clinical practice of services commissioned. Core e-learning training including basic awareness on adult safeguarding at

induction and further face to face training will be delivered to key front line staff during 2013.

Jeremy Walsh – Service Director, Wandsworth, SWLSTG NHS Trust

- E-learning – Safeguarding: The Trust appointed an e-learning lead to develop new e-learning packages to increase the accessibility of key clinical knowledge bases. The Safeguarding e-learning package is mandatory for all staff (clinical and non-clinical) and is supplemented by half day practice based sessions for those in a role requiring higher levels of competence.

- Centralised Data System: A new safeguarding adults software package has been added to the existing Safeguard system to record Serious Incidents, Complaints, Litigation, PALs etc.

- The centralised data system will provide operational and performance managers with the information they need to ensure compliance with safeguarding adults policy and maintain standards of practice. It will also provide an opportunity for detailed thematic analysis as it shows key information on timescales, those involved, and where incidents occurred etc.

- All Safeguarding Adult Managers (SAMs) and Alerting Managers (as defined by pan London policy) will be trained on how to enter data on this new centralised system. Access is limited to those who have had relevant training, and it is the SAMs who hold responsibility for updating the data records.

- Reports are generated on a weekly and monthly basis to provide senior management oversight as well as Trust Board reports, and other internal and external reporting requirements.

- Governance Structure: Over the past twelve months the Trust has been working to embed ownership of responsive safeguarding practice in day to day good practice, and to improve local and corporate governance, operational management oversight, outcomes and service user (and carer) experience. The key to this has been clarifying and distinguishing operational and governance responsibilities and accountabilities at all levels in the organisation.

- Adult safeguarding is every day business for all members of staff and all teams. Within direct services, this means the operational managers robustly oversee safeguarding practice, with strong local management, supervision and development of staff, with clear role designation and efficient allocation of

tasks. Oversight of performance and quality information at Borough, Directorate, and Corporate levels has been established.

- Safeguarding Adults Quality Account 2012/13: The development of a centralised data system to enable these two Quality Accounts to be measured has been a major achievement of lasting benefit. The centralised data system enables safer Trust wide governance of safeguarding adults cases, enabling tracking, quality assurance and audit. A further key development in Trust procedures is to offer 80% of service users whose cases went to case conference the opportunity to feedback on their experience of the safeguarding adults process. This target was met. The Trust is currently completing telephone and face to face interviews with people who wished to give feedback and the process of carrying out this investigation will inform both practice development and future feedback mechanisms.

David Flood – Lead Nurse for Adult Safeguarding, St Georges NHS Trust:

- St George's Healthcare NHS Trust has a commitment and responsibility to ensure that all patients receive safe, effective and dignified care. In particular we have a duty 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".

- The last twelve months has seen a number of reports that have highlighted considerable concerns with regard to the care and dignity of those most vulnerable within society. Of critical importance was the publication of the Francis Report which documented the significant failings at Mid Staffordshire NHS Foundation Trust. A significant aspect of adult safeguarding is to ensure we have the necessary processes and systems in place when responding to allegations of abuse and neglect, both within our organisation and externally within the communities we serve.

- St Georges is an active member of the Wandsworth Safeguarding Adults Partnership Board and has positive working relationships with the Adult Social Services Safeguarding Adults Team to ensure that any concerns about adults at risk are responded to in an effective and timely manner.

- All staff continue to receive basic awareness training at induction and as part of a yearly update, and we are rolling out additional training on Mental Capacity Act and Deprivation of Liberty Safeguards.

- Following an unannounced visit in January 2013, St Georges was found to be compliant with CQC Outcome 7- this was also reflected in the results of an external audit of St George's practices which identified that there were "clear governance and reporting arrangements for safeguarding within the health care trust."

DI Darrell Knowles – Safeguarding Lead, Wandsworth Borough Police

- Wandsworth Police continue to work closely with Adult Social Services to help safeguard vulnerable adults.

- We have an established Police Engagement Protocol, whereby adult services can report suspected cases of vulnerable adult abuse direct to the Public Protection Desk, rather than go through the control room. This process ensures that all referrals are initially assessed by officers with experience of recognising potential offences of adult abuse.

- If any offences are suspected, the matter will be investigated by the Community Safety Unit, which has the most experience of dealing with vulnerable adult abuse in a sensitive manner. The key focus of adult abuse investigations is to ensure the safeguarding of the victim, as well as proving criminal offences and successfully prosecuting offenders.

- The proper identification and investigation of vulnerable adult abuse has become a key priority for the Met in 2013-14. Since April 2013, for the first time, the Met has introduced a central database that enables all officers in the Met to record any incidents where vulnerable adults may be at risk of abuse. This is a big step forward in the Met's commitment to the safeguarding of vulnerable adults. It ensures a consistent approach, Met-wide, to effectively record and store information on vulnerable adults, which can then be shared with our partners. This enables adult services to make a more effective assessment of the needs of victims, thereby improving the whole safeguarding process.

Chris Jones – Safeguarding Lead, Housing Department, Wandsworth Council

- The Housing Department has well established policies and procedures for Safeguarding Adults and continues to develop and review these to ensure they reflect corporate and pan-London arrangements.

- Information on safeguarding is provided to all new staff, who also receive safeguarding awareness training as part of their induction with additional training provided for those staff whose responsibilities require specific training,

e.g. 9 Warden Services staff have attended a 'Contributing to Investigators' course. The possibility of providing e-learning as refresher training for housing staff is being explored, with Adult Social Services taking the lead.

- Reminders for housing staff about safeguarding are placed as news alerts throughout the year and safeguarding articles are published in Homelife, the Housing Department's newsletter which is delivered to all Council tenants and leaseholders. New contractors are made aware of their safeguarding responsibilities and provided with leaflets and a briefing document on how to make a safeguarding alert.

- Housing and Adult Social Services review all safeguarding alerts from housing staff on a quarterly basis to check the appropriateness of the alerts and any progress made or any outcomes reached. A total of 31 adult safeguarding alerts were made by the Housing Department to Adult Social Services during 2012/13 and the quality of these alerts, i.e. meeting the basic criteria for a safeguarding referral, has improved.

- The Housing Department continues to contribute to the training, development, performance and overall improvements of safeguarding adults policy at the Council and, in the Audit Report of the Wandsworth Safeguarding Adults Partnership Board, received an 'Excellent' rating for its safeguarding arrangements.

Audit of the Safeguarding Adults Partnership Board

The Safeguarding Adults Partnership Board has strategic responsibility for safeguarding adults arrangements in Wandsworth, meeting on a quarterly basis. Key partner agencies are represented at a decision-making level and there are two service user representatives on the board. A shared chairing arrangement between the Adult Social Services Directors for Wandsworth and Richmond, assuming responsibility to chair and provide independent scrutiny and challenge of the respective Boards, is embedded. The Board has continued to report directly to the Community Safety Partnership and has cross- representation with the Safeguarding Children's Boards.

An external audit of the Board was commissioned in the reporting year, to ensure that the Board is able to provide effective strategic leadership in advance of anticipated legislation, and reported in July 2012. The overall outcome was positive and concluded that:

- *Wandsworth Safeguarding Adults Partnership Board is travelling in the right direction in terms of its aim of being an effective Safeguarding Board meeting the legislative requirements. The last year has seen a change in focus to include structured board meetings, with clear planning and reviewing of agenda items.*
- *The findings of the audit of the individual agencies demonstrate the investment agencies have made in the safeguarding agenda. There are examples of excellent practice across the organisations. The board needs to produce clear strategies on which agencies can underpin their safeguarding business plans to enable the board to have a strategic oversight of safeguarding work in Wandsworth. The board needs to be transparent in its decision making and open to scrutiny.*
- *Board members are all accountable to ensure that the board is an effective strategic board. To achieve this members need to constantly challenge themselves and each other as to the business discussed and agreed at board level. Subgroups need to continue to be used effectively to conduct the work of the board with the support of board members.*
- *In summary, if the Wandsworth Safeguarding Adults Board continues to be committed to reflecting and challenging its functioning it has the potential to be a highly effective board in the local infrastructure, meeting the statutory requirements introduced by the legislating of Safeguarding Boards.*

The audit included recommendations for further improvement which were adopted and progressed through a Board Audit Action Plan, initiated in October 2012 and monitored at subsequent Board meetings. This included the following recommendations and resulting actions:

- Clarity on the intended outcomes for adults at risk and carers – the Board is participating in the national *Making Safeguarding Personal* project in 2013-14.

- Review of Board reporting arrangements – the Board decided to continue to report to the Community Safety Partnership and also to develop reporting arrangements with the emerging Health and Wellbeing Board. The Board also reports to the Council Overview and Scrutiny Committee and to relevant partner agency boards.

- Clearer Board decision making – the Board has developed a clearer strategic agenda, with themed discussions on key issues, and terms of reference of sub-groups have been reviewed to clarify their role in following up strategic decisions.

- The development of a Board Memorandum of Understanding – a Board Memorandum of Understanding was endorsed by the Board with a clear statement on the membership and responsibilities of Board members

- The development of a Board decision- making matrix tool to inform agenda priorities – a Submission of Proposals to the Board form was endorsed, with issues to be weighted according to risk.

- The development of individual agency action plans - individual agency action plans were drawn up to ensure that participating agencies are contributing fully to the strategic work of the Board, and progress was monitored in a meeting of agency safeguarding leads.

- A review of Board membership, including the strategic level and an improved service users and carers voice on the Board – Board membership has been reviewed with the addition of Adult Social Services Commissioning representation; there are two service users on the Board, Wandsworth Carers Centre is represented and a decision was taken to invite Healthwatch to be represented from 2013-14; further work is required to renew General Practitioner representation and Service Provider representation will also be considered in the new reporting year.

- The development of a Board communication strategy – a Board communication strategy has been endorsed by the Board.

- The development of an improved Board web page with accessible information – the safeguarding adults web page was rebuilt during the reporting year and the availability of information improved.

- The development of a joint Board budget – an annual budget was agreed by member agencies for 2012-13 and has been agreed for 2013-14, to meet staffing, training and publicity costs.

- The development of closer strategic arrangements with Safeguarding Children – there is cross-representation and agreed joint agenda issues between the Safeguarding Adults and Safeguarding Children Boards, and a Safeguarding Adults and Children's Sub-Committee was developed in the reporting year to take forward agreed joint actions.

Joint budget

The Board agreed a joint budget to cover safeguarding adults commitments during 2012-13 and 2013-14. This was based on the agreed Board commitment to staffing, training, publicity and Deprivation of Liberty Safeguards and the associated costs. Adult Social Services retained responsibility for staffing costs, comprising the Safeguarding Adults Team and Deprivation of Liberty Safeguards. The remainder of the budget allocation covered training and publicity and was divided equally between Adult Social Services, the Clinical Commissioning Group, St George's NHS Trust, South West London and St George's NHS Trust, Police, and for the first time by Wandsworth Children's Services Department.

Audit of the Safeguarding Adults Team

The staffing complement in the Wandsworth Adult Social Services Safeguarding Adults Team has been maintained, comprising a Safeguarding Adults Policy and Development Manager, Senior Coordinator, Coordinator, and five Administrators.

A root and branch external audit of the working of the Safeguarding Team was commissioned at the end of the previous reporting year and reported in March 2012. The outcome was very positive and the team was commended for the high quality of work produced in providing a service to internal and external customers. This led to the development of a Safeguarding Adults Team Operational Plan in the reporting year and an inter-agency workshop which endorsed the service provided by the team. The key team functions are outlined below:

- Consultation on practice standards to professionals across agencies
- Chairing case conferences and high profile safeguarding meetings
- Coordinating out of borough safeguarding investigations for which Wandsworth has host authority responsibility
- Coordinating and chairing service level concerns meetings
- Administration and minute taking of strategic and operational safeguarding meetings
- Quality assurance and performance monitoring function, including service user feedback and attendance at safeguarding meetings
- Coordination of practice workshops

- Contribution to inter-agency meetings, including MAPPA and MARAC.

A further internal audit of the safeguarding service and team during the reporting year reached a positive qualified assurance outcome, as did a comparable internal audit in 2010.

It is a continued challenge to provide a quality service with the same resources and a rising tide of alerts, and the operational approach of the team will continue to be reviewed by the Safeguarding Adults Policy and Development Manager in the new reporting year to ensure that standards are maintained.

Safeguarding case study

- When AC moved to a Wandsworth nursing home, placed by another local authority, it transpired that he was in arrears with his contribution to fees and was in receipt of a minimal personal allowance.

- During a case review, a relative (who was the appointee) was made aware of the financial concerns and he agreed to sign a direct debit form. Payments then defaulted over many months.

- The placing community social work team raised a safeguarding alert with the Wandsworth Safeguarding Adults Team in response to the alleged financial abuse of AC. Wandsworth coordinated the safeguarding response and a strategy meeting was held.

- An interim protection plan was implemented, including transfer of appointeeship to the placing borough's Client Affairs Team to prevent any further loss of finances to AC, and liaison with the Department of Work and Pensions ensured that there was no loss of funds whilst this arrangement was set up.

- A formal mental capacity assessment was completed, specific to AC's ability to manage finances.

- A Wandsworth Police led investigation was initiated.

- At a second case conference, Wandsworth Police reported that after making all necessary checks and gathering relevant information and documents from the

Department of Work and Pensions, they had sufficient evidence to arrest and interview the relative on charges of fraud.

- The relative was arrested and admitted to offences of fraud, leading to a successful prosecution and conviction in court.

Deprivation of Liberty Safeguards

The Safeguarding Adults Team continues to be responsible for coordinating and development of Deprivation of Liberty Safeguards in the borough. A part-time Senior Coordinator is part of the team establishment and administrative support is provided from within the team. This enables close working on cases and contributes to both the prevention of abuse and of unauthorised deprivation of liberties. In the new reporting year a change to national guidelines will mean that the team will have supervisory responsibility for authorising Deprivation of Liberty Safeguards in hospital settings, in addition to current supervisory responsibility for authorisations in care and nursing homes.

The number of Deprivation of Liberty Safeguards assessments and authorisations for 2012-13 is comparable to previous years and the Coordinator is engaged with Adult Social Services, service provider and hospital staff in raising awareness and encouraging reporting:

Number of DoLS referrals, including reviews (referrals was previously called assessments)	Local Authority	18	(London average 20.6)
	Hospital	9	(London average 7.4)
	Total	27	
Number of DoLS authorisations	Local Authority	9	(London average 12.5)
	Hospital	3	(London average 3.8)
	Total	12	

Deprivation of Liberty Case Study

- AD, a man of 33 with a learning disability who is living in a residential home, made an allegation of physical abuse against his mother following a weekend home visit.

- This led to a combined safeguarding and deprivation of liberty safeguards response.

- A Deprivation of Liberty Safeguards urgent authorisation was issued following the allegation. The purpose was to stop overnight visits until the safeguarding allegation had been investigated.

- The Safeguarding investigation was inconclusive and, following a meeting with the care provider and the social worker, the authorisation was lifted prior to both the safeguarding case conference and the original authorisation end date. This was to reduce the distress that preventing home visits was having on AD and was risk assessed as part of a protection plan to ensure safety.

- The renewal of overnight stays occurred without incident.

- This is a positive example of safeguarding adults and the deprivation of liberty safeguards working effectively together in a safe and person-centred way**.**

Beyond Winterbourne View Joint Local Plan

The serious institutional abuse of patients at Winterbourne View, a private hospital for people with learning disabilities in South Gloucestershire, was uncovered in May 2011. The subsequent serious case review pointed to failings by partner agencies in arranging local community placements and in recognising the warning signs of institutional abuse. In response, the Department of Health required local authorities and health authorities to develop action plans to address serious institutional abuse.

The Wandsworth SAPB *Beyond Winterbourne View Joint Local Plan* was endorsed by the Board in January 2013 and progress of this Board priority area is monitored at the quarterly Board meetings. Progress has been achieved in the following key areas:

- Completion of a local joint health and social care self-assessment, involving the Learning Disability Partnership Board, for submission to the joint Association of Directors of Social Services in London and NHS London programme

- A register of people with learning disabilities in institutionalised hospital and care settings has been compiled, with a named Clinical Commissioning Group lead responsibility to maintain the list. This comprises 13 health funded service users in hospital settings, 2 health funded service users in care and nursing home settings and 2 local authority funded service users in private hospitals. It is not intended as a list of all local authority service users in care settings. An

additional list of 31 continuing health care service users with learning disabilities has also been compiled.

- All 17 service users on the Learning Disability Register in Wandsworth have received up to date reviews and the quality of reviews has been scrutinised.

- A joint health and social care team is in the process of identifying local community options for service users on the register and at least 12 people are in the process of moving to community placements.

- Targeted training of staff and residents in care and nursing homes is covered later in this report.

- Contractual requirements on service providers in regard to quality standards and safety are under review and will be a continued priority into the new reporting year, including reinforcement of key arrangements such as reporting, whistle blowing, open access to visits by families and professionals, restraint; and service user input to contract monitoring.

- The completion of regular and thorough local authority case reviews has been a priority in recent years and ensuring collaboration with health on joint reviews when applicable will be a priority moving into the next reporting year.

- Close collaboration with the Care Quality Commission has been maintained with involvement on the Board and joint working on safeguarding and service level concerns.

- The development of the Professional and Service Standards Framework, Quality Control Panel, Service Level Concerns Protocol and monitoring of service provider safeguarding activity are covered later in this report.

- The response to Winterbourne will be the theme of the Wandsworth Safeguarding Adults Conference in June 2013.

Professional and Service Standards Framework

As a core part of the response to Winterbourne View, the Professional and Service Standards Framework has been developed and will be a priority area for the Board in the new reporting year. The purpose of the Framework is to agree a set of clear service quality standards across statutory and provider organisations, including safeguarding

standards, alongside monitoring of these standards through the newly established Quality Control Panel (covered later in this report).

This is an emerging project, comprising representatives of Adult Social Services safeguarding, commissioning, policy and performance, and operational sections, alongside Clinical Commissioning Group commissioning. Terms of reference have been agreed and the group will report to the Board in 2013-14.

Clinical Commissioning Group

The change in primary health care with the replacement of Primary Care Trusts with Clinical Commissioning Groups from April 2013 will be met with a continued commitment to representation on the Board.

The Primary Care Trust has been a core agency in the development of safeguarding in the borough and is committed to progressing Board priorities in 2013-14. These include the renewal of General Practitioner representation on the Board, the transfer of Deprivation of Liberty Safeguards responsibilities, the further development of robust and joint case reviews, and the further development of Serious Incident investigations integrated with safeguarding.

Making Safeguarding Personal

The Local Government Association published a report entitled *Safeguarding Adults – learning from peer challenges* in April 2013. This outlined key learning from safeguarding peer challenges completed across 12 local authorities.

The report findings included a concern nationally of variable engagement with service users. There was considered to be:

- an emphasis in policies and procedures on involvement but not control by service users
- a tendency for people to feel driven through a process and not asked the outcomes they want
- a tendency for service users, when asked, to want outcomes such as feeling safe, receiving justice and maintaining relationships.

This has contributed to the development of the Local Government Association/Association of Directors of Adult Social Services sponsored *Making Safeguarding Personal* initiative in 2013-14 in which a number of safeguarding boards, including Wandsworth, will demonstrate engagement with service users in

establishing and monitoring desired outcomes of safeguarding investigations. This will be a key priority area for the Board in the new reporting year and beyond.

Service User Forum

The Safeguarding Adults Service User Forum continued with membership open to service users with an interest in safeguarding adults as well as those who have experienced safeguarding adults investigations. The group had previously participated in the development of an accessible publicity leaflet for people with learning disabilities. Terms of Reference were agreed and facilitation of the group has continued to be the responsibility of a Day Centre service user and manager, who are dedicated to developing the initiative and have forged extensive links with partner agencies and service providers. The service user is a representative on the Safeguarding Adults Partnership Board but attendance has been restricted due to ill health. The forum is now a standard item in case conferences.

Unfortunately, membership of the forum remains small. To support the principles of *Making Safeguarding Personal* at a strategic level, it will be a Board priority in the new reporting year to energise the forum via the use of publicity flyers and renewed attendance at service provider meetings to promote involvement.

1.3 Policy and Procedures Sub-Group

Policy and Procedures

The *London Multi-Agency Safeguarding Adults Policy and Procedures, with Wandsworth local arrangements,* were launched in January 2011 and embedded in practice during the current reporting year. Wandsworth continues to apply a formal proportionate levels system in investigating adult abuse. A *Reporting and Investigation Process Flowchart***,** contained in the local procedures, has been updated to provide clear guidance on the reporting and investigation process and timescales. There is an emphasis on clear thresholds and three proportionate response levels to be exercised with professional judgement. There is a continued emphasis on involving adults at risk as fully as possible in the process. The key local procedures are outlined in the following sections of this report.

Police Engagement Protocol

The **Police Engagement Protocol** and **Police Reporting Form,** a joint initiative implemented by Wandsworth Adult Social Services and Wandsworth Police in 2009 which has led to improved direct reporting and joint working on investigations, has been updated to reflect changes in lead officer contacts and learning from a case on providing thorough evidence in case conferences. Priorities in the new reporting year,

in the context of an increased community policing role and a strain on senior officer availability for attendance at meetings, will be:

- Increasing referrals by the Police, with the adaption of the Merlin reporting system to safeguarding adults and the anticipated development of a Multi-Agency Safeguarding Hub (MASH).

Service Level Concerns Protocol

A multi-agency Service Level Concerns Protocol was established in 2009 and is incorporated in the policy and procedures. It provides a framework for a prompt and robust response to serious concerns about quality of care and safety in service provision. This has been updated to provide improved clarity and has been used successfully to drive up quality standards in nursing homes and mental health inpatient wards giving cause for concern in the reporting year. This has primarily involved:

- meetings to monitor service provider action plans, with attendance by the Safeguarding Adults Team, Adult Social Services Commissioning and Operational, Clinical Commissioning Group and Continuing Care, Service Provider senior managers, the Care Quality Commission and Police

- cessations of new admissions pending service improvements

- updated case reviews

- commissioning and contract monitoring support to service provider managers and staff

- inspections and regulatory action by the Care Quality Commission.

Key priorities of the Board in the new reporting year will be:

- Shifting the emphasis from reacting to service level concerns when they arise to proactively addressing concerns raised through an analysis of service provider safeguarding activity and through the Quality Control Panel.
- Placing an increased emphasis on service level concerns in domiciliary care.

Health led investigations

There has been evidence of effective joint working between health and social care in reporting and investigating abuse in the reporting year. It will be a priority of the Board in 2013-14 to further improve these arrangements, with particular attention to the following areas:

- It is established practice for serious incident and safeguarding investigations to be amalgamated when this is appropriate. There will be increased emphasis on independent lead investigation and scrutiny of investigation roles in health, towards more conclusive outcomes.
- In a similar vein, there is a commitment by the Clinical Commissioning Group to offer increased contribution to and scrutiny of safeguarding investigations involving issues of nursing care, particularly in nursing homes.
- There is in place an effective screening process for pressure ulcer care and safeguarding when patients are admitted to St George's Hospital. There will be an emphasis on developing similar practice in nursing homes and community settings.

Self Directed Support

The arrangements for service users to receive self-directed support were progressed during the reporting year in line with national requirements. The Safeguarding Adults Partnership Board recognises the importance of these changes in radically improving empowerment and enhancing the quality of life of service users through taking control of individualised care arrangements. It is also recognised that there is a potential risk of abuse due to the reliance on unregulated services. Safeguards have been included in the assessment, service planning and review stages of the process, with line management oversight of the management of risks and abuse concerns, to ensure effective prevention and response to abuse. The safeguards will be subject to ongoing review in the next reporting year.

1.4 Performance Assessment and Monitoring Sub-Group

Quality Control Panel and monitoring service provider safeguarding activity

The Quality Control Panel has recently been developed, linked to the Professional and Service Standards Framework, as a conduit for concerns about quality standards and safety arising from a range of areas including safeguarding, service level concerns, complaints, commissioning, contract monitoring and reviews. This will be a means of ensuring that different sections across health and social care are communicating in a joined up approach to establishing and responding to concerns.

Contributing to this initiative, a tool has been developed to provide monitoring of safeguarding activity across service providers from the start of 2013-14. This covers the number and type of safeguarding alerts, relationships of persons alleged to have caused harm and outcomes; for all service providers across care and nursing homes, domiciliary care, hospitals and mental health inpatient wards. The monitoring tool will contribute to decisions about service level concerns responses.

Review of Frameworki recording system

A review of the Frameworki recording system in Adult Social Services was completed in the reporting year and an updated system is in place from April 2013. This is more accessible to practitioners and provides a more comprehensive record of strategy discussions and protection plans. Updated guidance on recording has been developed to complement the change and training continues to be available to staff.

There continues to be a separate RIO mental health recording system across the boroughs within the St George's and South West London NHS Trust. To improve the availability of measurable outcomes a linked recording system, ULYSSES, has recently been developed with reporting to a regular Mental Health Performance meeting.

A bi-monthly performance report on safeguarding activity and trends is produced (covered in the next session) and will be reported to the Board in 2013-14, along with improved reporting on compliance with safeguarding tasks and timescales.

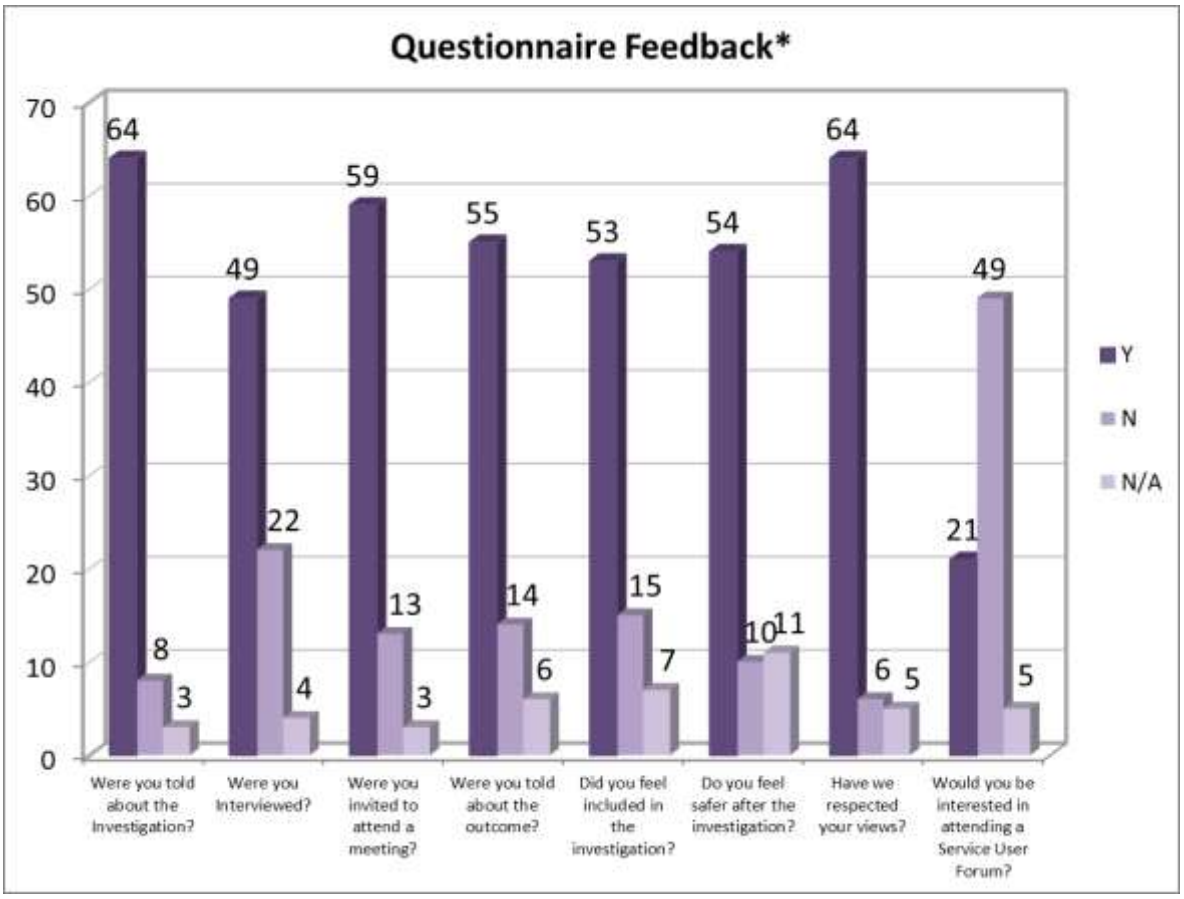
Case Audits

General safeguarding case audits were completed during the reporting year by line managers and the Safeguarding Adults Policy and Development Manager. Learning from these and further case audits, both general and themed, will contribute to a review of practice and recording guidance and practice workshops in the new reporting year. A robust auditing programme will also be commissioned in 2013-14, consisting of themed auditing of safeguarding thresholds. These will contribute in the new reporting year to a clearer and more robust Board multi-agency performance framework.

Service User Feedback

A Service User Feedback form has been developed and improved during the reporting year to gauge involvement and satisfaction with outcomes. To improve the rate of returns, the completion of the form is agreed as a standard item at Case Conferences and completion is monitored by the Safeguarding Adults Team. A more comprehensive feedback arrangement, incorporating independent interviews with a

sample of service users will be developed in 2013-14 as part of the *Making Safeguarding Personal* initiative.



**from a total of 75 responses received by the end of June 2013*

Other performance monitoring

The Safeguarding Adults Team has expanded its performance monitoring function and reports on progress to the Performance Assessment and Monitoring Sub-Group. These include attendance by agencies at safeguarding meetings which demonstrates a high and improving level of attendance by most agencies; chairing and minuting of safeguarding meetings by the Safeguarding Adults Team which highlights that the vast majority of case conferences and host authority meetings are chaired by the team. There is an increasing strain on minute taking resources and a review of practice in arranging meetings will be undertaken in the new reporting year to maximise the availability of designated minute takers whilst maintaining a high standard of performance.

1.5 Safeguarding activity and trends

This section provides an analysis of performance against national reporting requirements and of emerging trends, with reference to the performance of comparator boroughs and to related priority actions to improve practice in preventing and responding to abuse.

Alerts and referrals

Number of alerts and referrals: The year on year increase in safeguarding adults alerts in Wandsworth continued during the reporting year, rising from 868 alerts in 2011-12 to 1,079 alerts in 2012-13.

The level of alerts in Wandsworth is higher than the comparator group of London boroughs and is the 5th highest in London, adjusted to population figures.

The rise in alerts is a reflection of the continued multi-agency investment in awareness raising through training and publicity,

Alerts progressing to referrals: For the past two years the number of alerts progressing to referrals, in which a Safeguarding Adults Manager has made a judgement that there are grounds to suspect abuse and thereby to trigger an investigation, has also been calculated. This separation of alerts and referrals was not completed prior to 2011-12.

The referral rate has remained constant, and is close to the figure in comparator boroughs. This represents a reduction in the percentage of alerts progressing to referrals;

- 66% (572) in 2011-12
- 53% (573) in 2012-13.

The increase in alerts not progressing to referrals could indicate a tendency towards inappropriate alerts by reporting agencies or appropriate threshold decisions by Safeguarding Adults Managers. This will be examined in an audit of alerts not progressing to referrals to be completed in 2013-14, to gauge whether valid and proportionate judgements are being made about whether abuse is suspected or there is a significant risk of abuse.

Repeat referrals: There is a slightly lower incidence of repeat referrals in Wandsworth, totalling 25 in the reporting year, than in the comparator London boroughs, indicating a higher rate of resolving safeguarding concerns.

Alerts and referrals by client type: There has been a year on year trend of rising mental health and reducing learning disability alerts, although this has stabilised from 2011-12 to 2012-13. The proportion of older and disabled people is less than that of the comparator group of London boroughs;

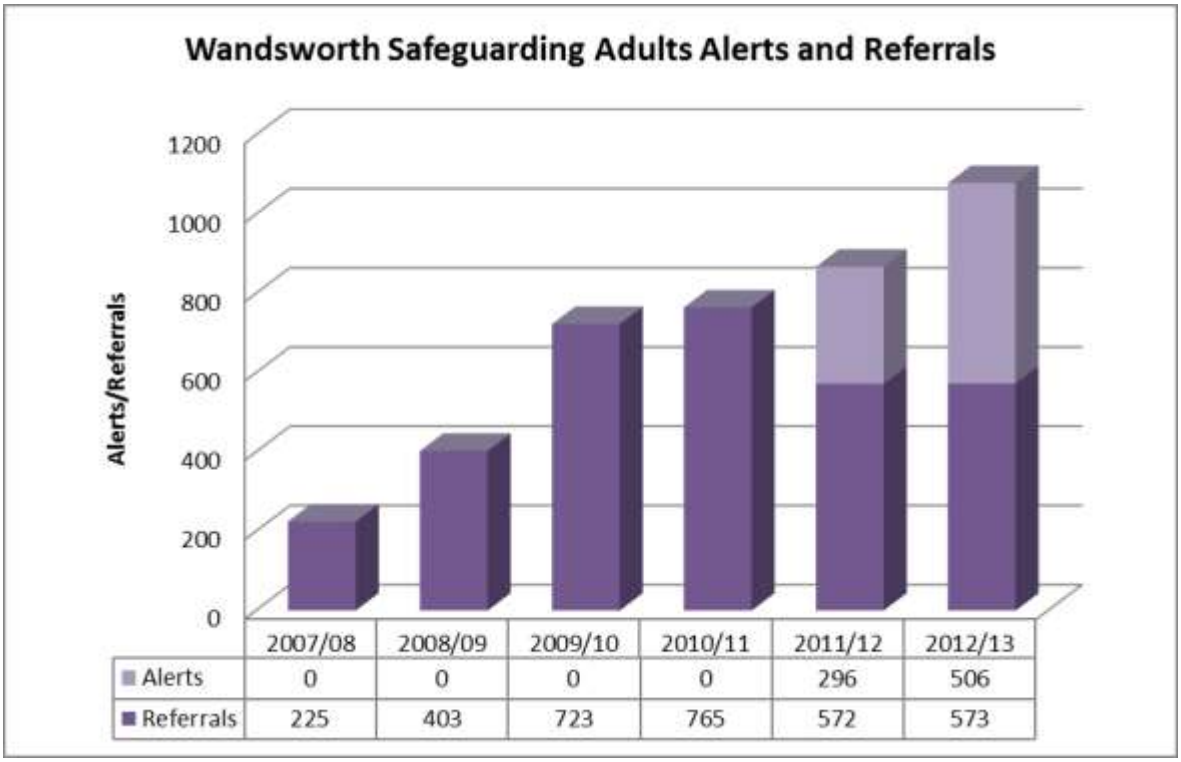
- Older persons and disability alerts - 46% to 50% (44% of referrals)
- Mental health alerts - 26% to 28% (30% of referrals)
- Learning disability alerts - 19% to 19% (21% of referrals)

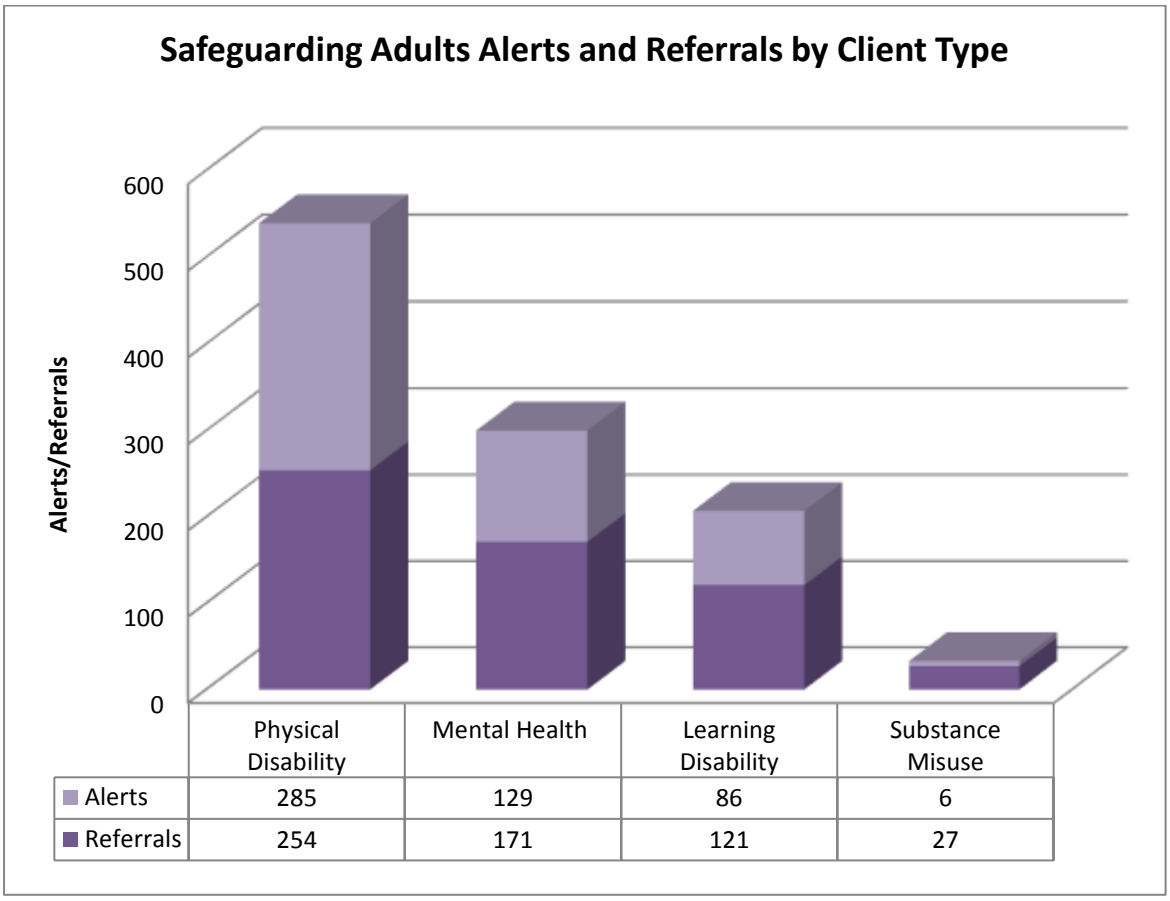
There is consistency between service areas on thresholds, although Older Persons and Disabilities do progress a lower percentage of alerts to referrals than other service areas.

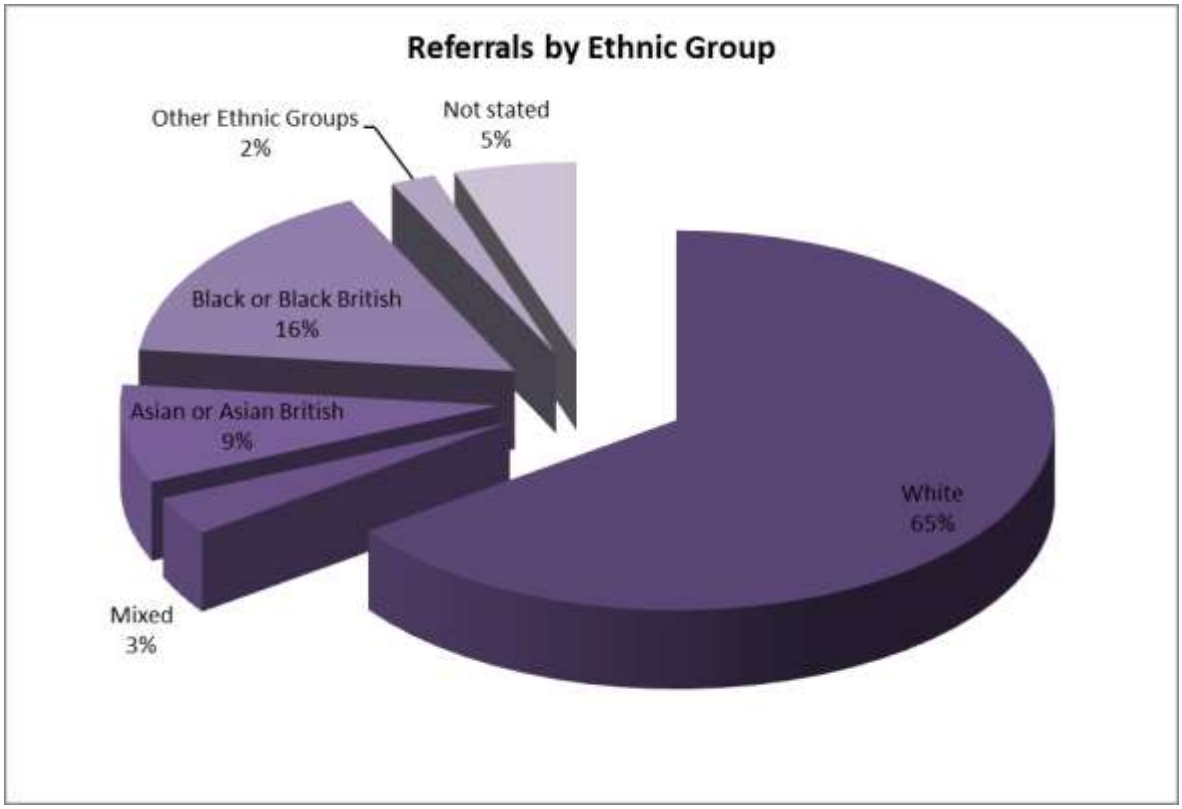
Alerts and referrals by ethnicity: The ethnic breakdown of referrals has remained fairly constant from the previous reporting year. The proportion of White British referrals is significantly higher than any other ethnic group, but is under represented in comparison with population figures (2001 Census); with the second highest proportion of referrals relating to Black or Black British Caribbean service users, who are slightly over represented;

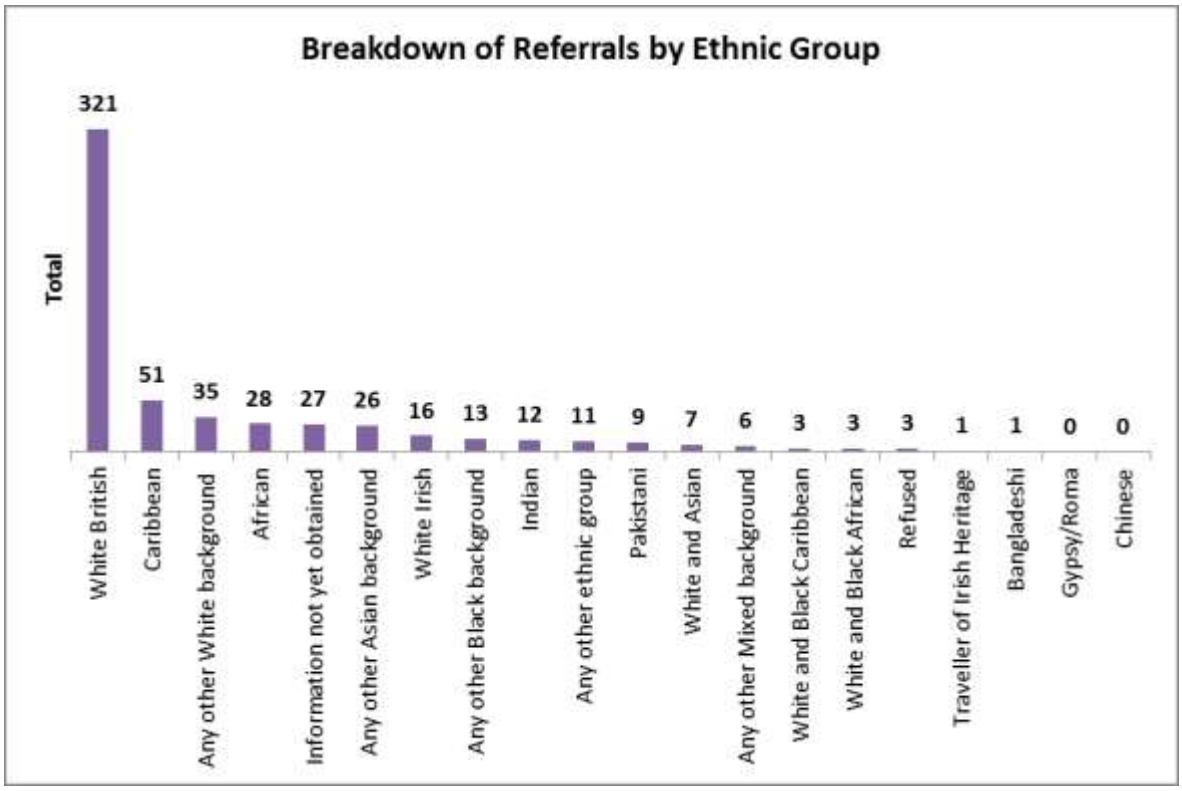
- White British - 56% of referrals both years (78% of population)
- Black/Black British Caribbean - 9% both years (5% of population)

It is not known if these figures demonstrate prevalence or reporting of adult abuse. The figures for safeguarding children referrals in Wandsworth for the reporting year also showed an over representation of referrals from Black, Asian, Minority and Ethnic communities.


Wandsworth Safeguarding Adults Alerts and Referrals
Alerts/Referrals
1200
1000
800
600
400
200
0
2007/08 2008/09 2009/10 2010/11 2011/12 2012/13
Alerts 0 0 0 0 296 506
Referrals 225 403 723 765 572 573


Safeguarding Adults Alerts and Referrals by Client Type
Alerts/Referrals
600
500
400
300
200
100
0
Physical Disability
Mental Health
Learning Disability
Substance Misuse
Alerts 285 129 86 6
Referrals 254 171 121 27


Referrals by Ethnic Group
Other Ethnic Groups
2%
Not stated
5%
Black or Black British
16%
Asian or Asian British
9%
White
65%
Mixed
3%


Breakdown of Referrals by Ethnic Group
Total
321
51
35
28
27
26
16
13
12
11
9
7
6
3
3
3
1
1
0
0
White British
Caribbean
Any other White background
African
Information not yet obtained
Any other Asian background
White Irish
Any other Black background
Indian
Any other ethnic group
Pakistani
White and Asian
Any other Mixed background
White and Black Caribbean
White and Black African
Refused
Traveller of Irish Heritage
Bangladeshi
Gypsy/Roma
Chinese

Source of referral

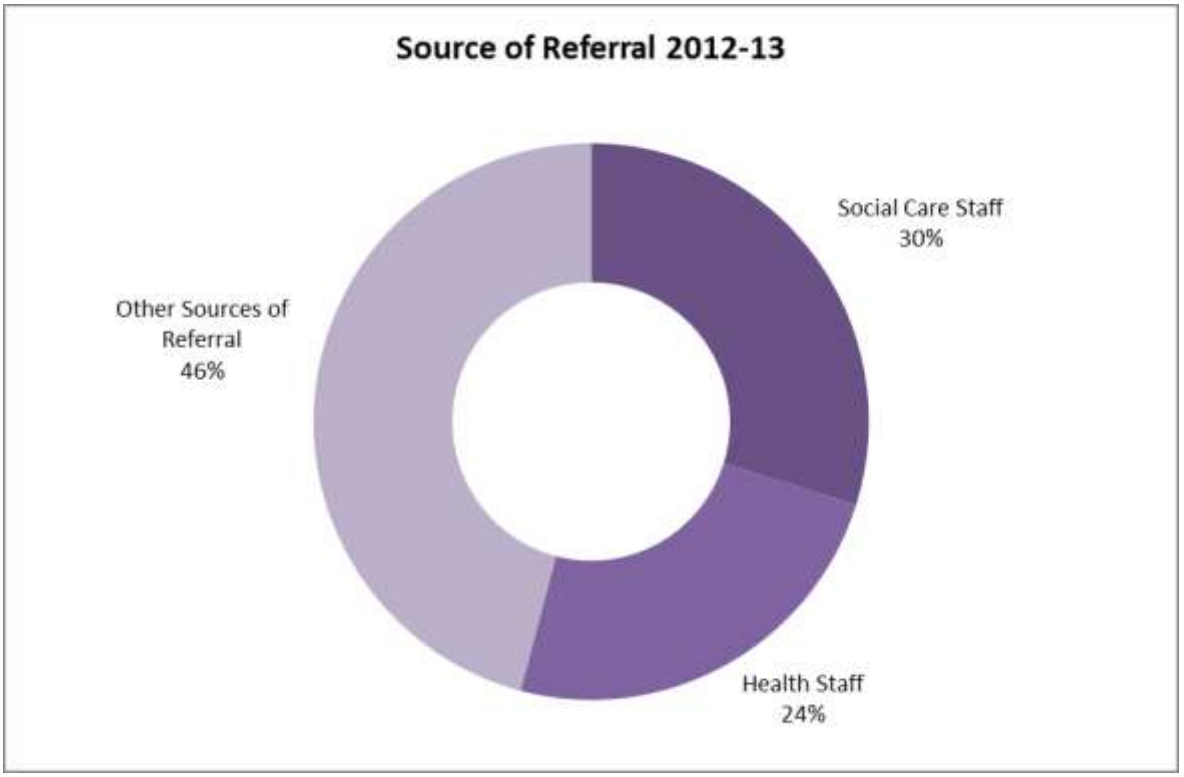
The highest proportion of safeguarding adults referrals continue to be made by Social Care staff, primarily social workers.

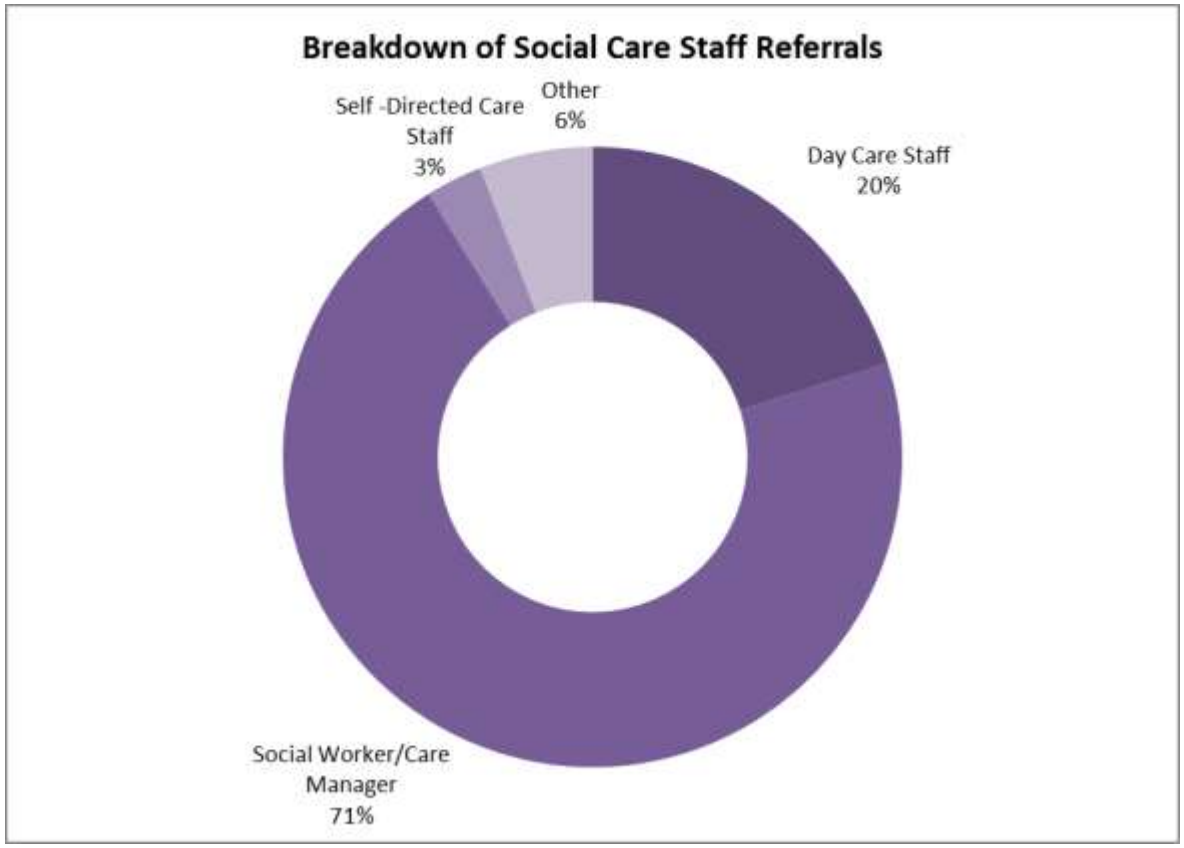
Health staff referrals have increased in recent years but stabilised in the reporting year, with primary health care referrals falling and mental health inpatient ward referrals remaining high.

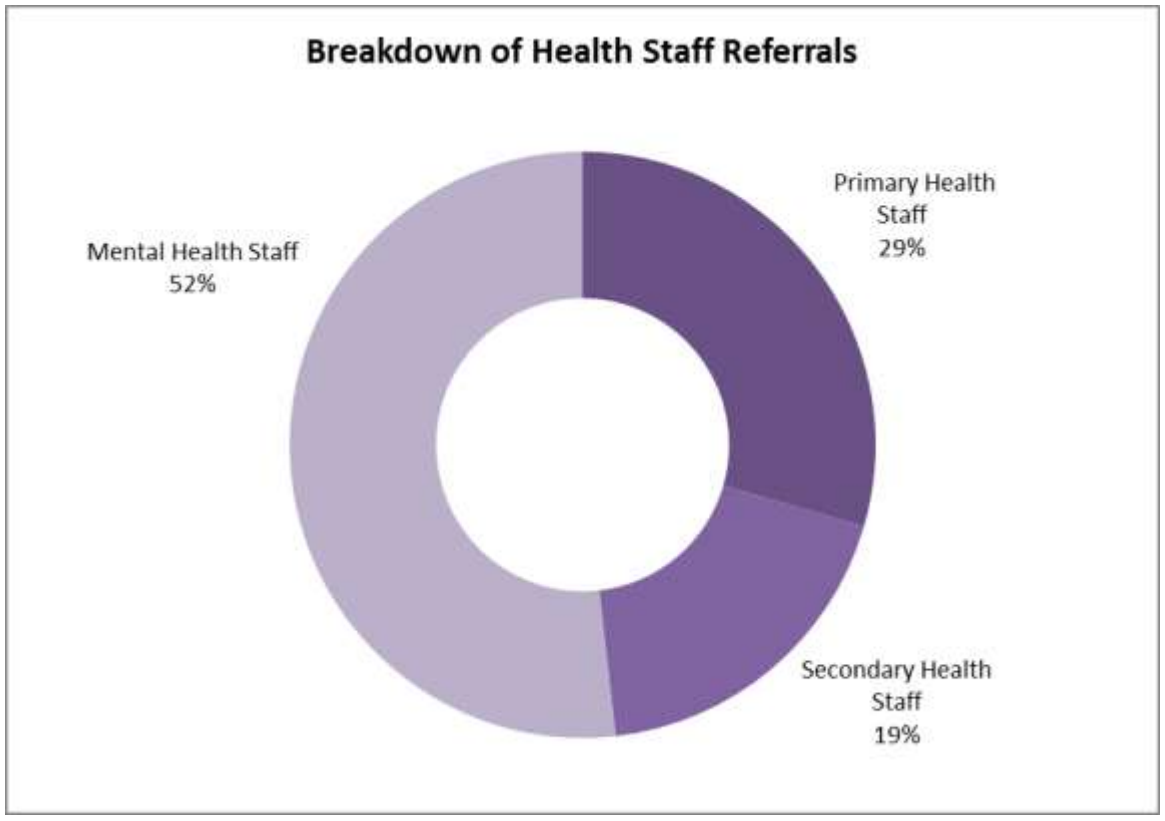
Monitoring service level improvements in mental health inpatient wards will remain a Board priority in 2013-14 through follow up of service level concerns overview meetings.

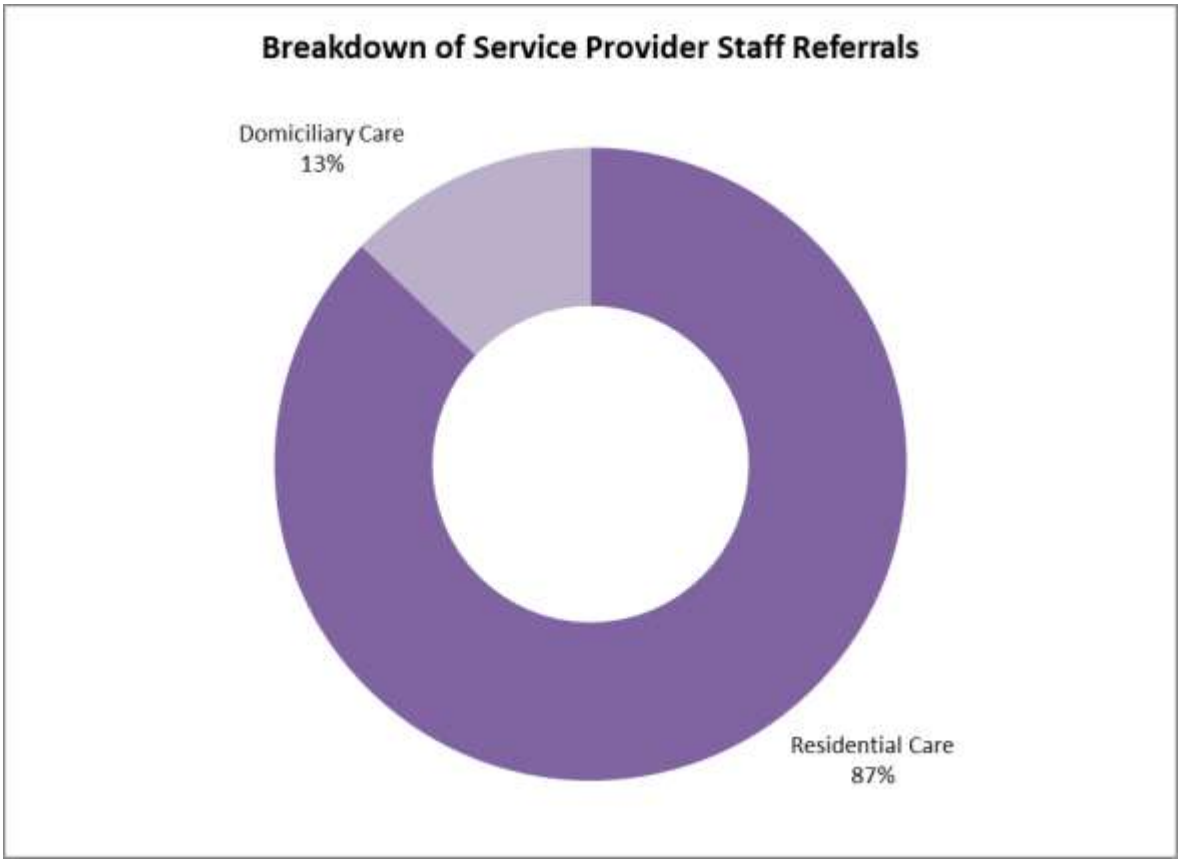
The level of referrals by care and nursing homes remains low relative to comparator boroughs. There will be a continued emphasis on targeted training and publicity to staff, alongside training and publicity to residents as a new initiative, in the next reporting year.

There remain a small proportion of referrals by Domiciliary Care staff and reporting by Self Directed Support staff remains negligible. These areas will be addressed by further improved monitoring of service provider safeguarding activity in 2013-14.




Breakdown of Social Care Staff Referrals
Other 6%
Self -Directed Care Staff 3%
Day Care Staff 20%
Social Worker/Care Manager 71%


Breakdown of Health Staff Referrals
Primary Health Staff 29%
Mental Health Staff 52%
Secondary Health Staff 19%



Type of abuse

Type of abuse: The proportion of reported abuse types has remained fairly stable in recent years, with physical abuse remaining highest, although there has been a reduction in the proportion of psychological abuse. The below figures demonstrate the change from 2011-12 to 2012-13:

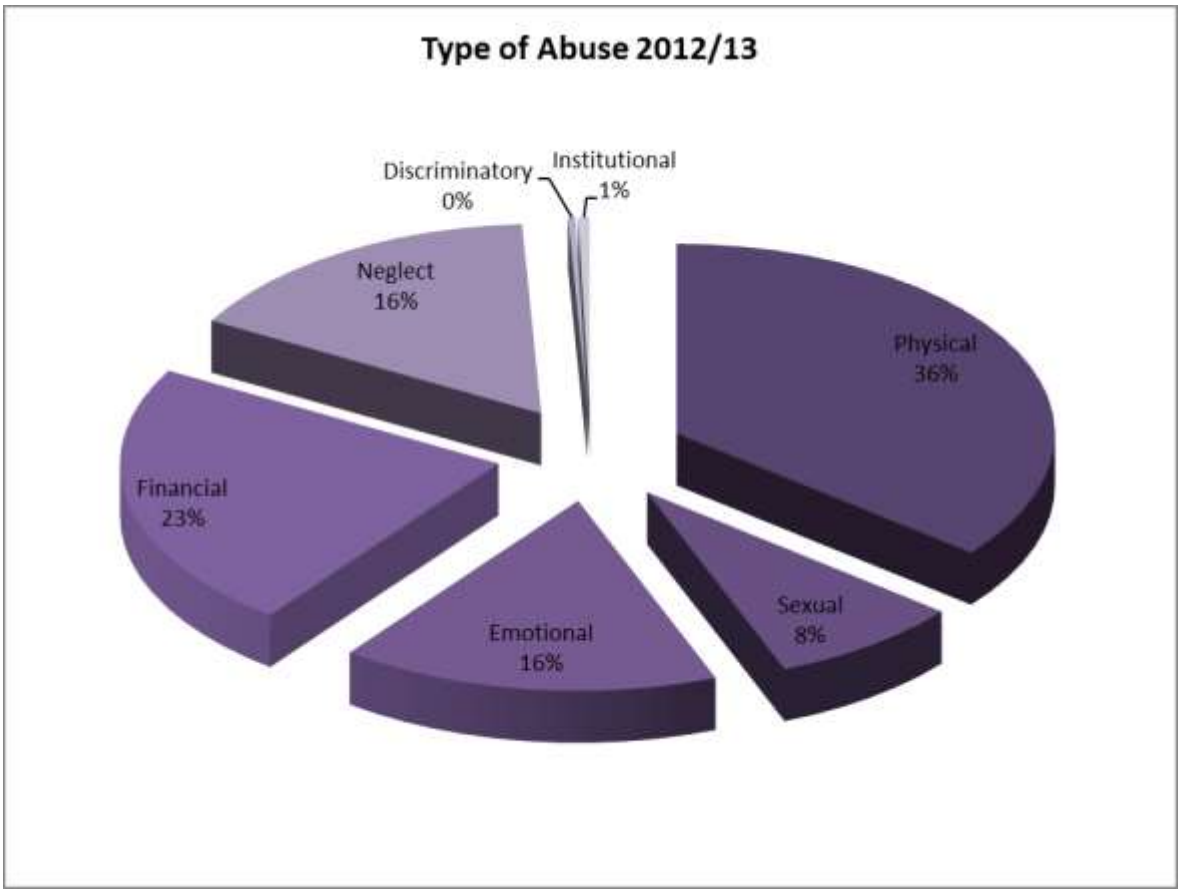
- Physical abuse - 38% to 36%
- Financial abuse - 26% to 23%
- Psychological abuse - 25% to 16%
- Neglect - 15% to 16%
- Sexual abuse - 10% to 8%

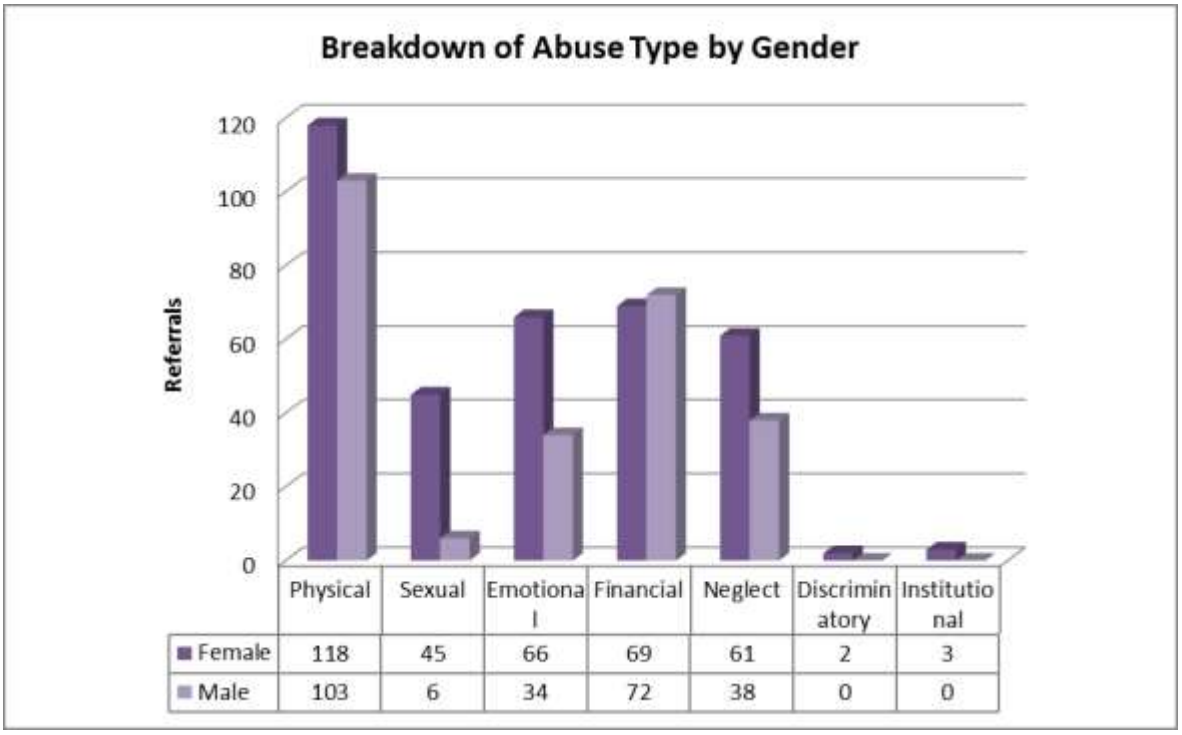
The recording of discriminatory and institutional abuse both remain very low, despite active service level concerns responses to serious institutional abuse, and will be picked up in a review of practice and recording guidance in the new reporting year.

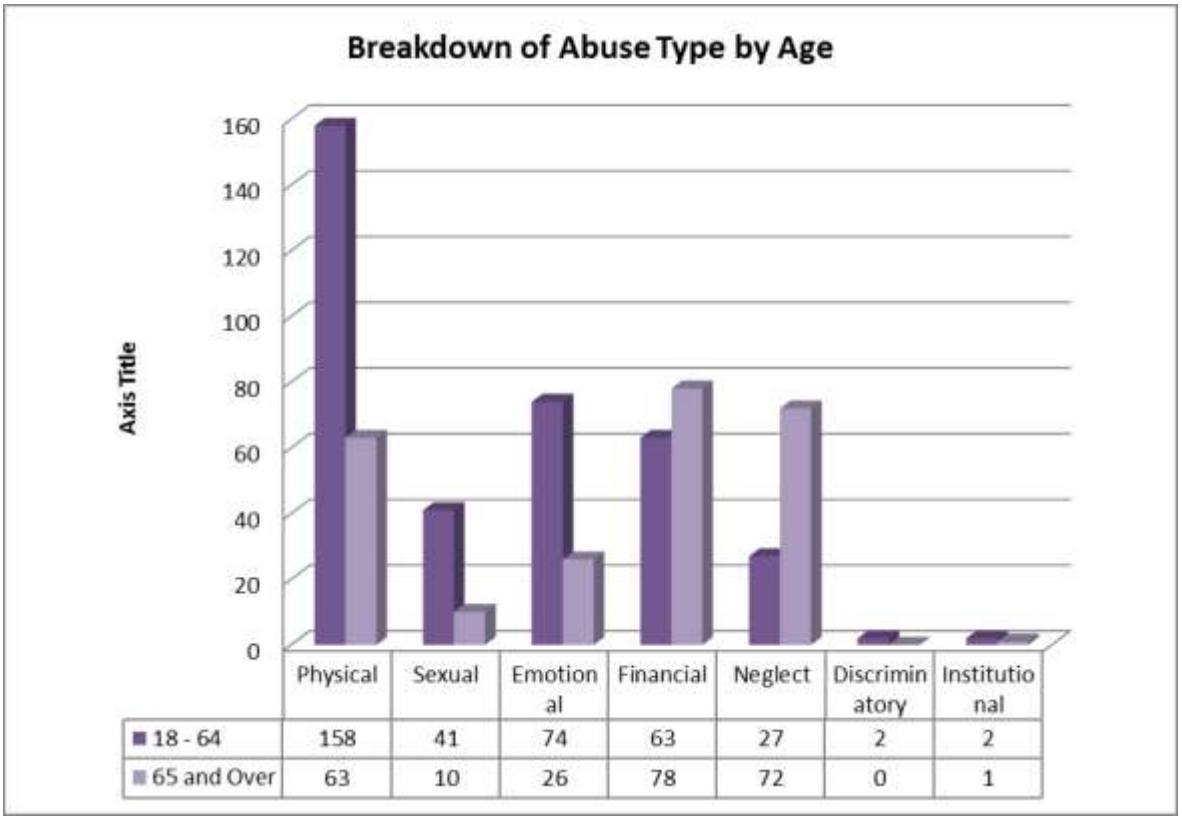
Gender: As expected, the reporting of abuse is higher in relation to females, amounting to 59% of total referrals, compared to 60% in the previous year. The incidence of abuse was higher for females in relation to all types of abuse except

financial abuse, in line with the previous year. The highest variation between genders continues to be in relation to sexual abuse and there will be a renewed contribution by the Safeguarding Adults Team to MARAC and the Violence against Women and Girls (VAWG) Forum in the new reporting year.

Age: The prevalence of financial abuse and neglect, the latter very markedly, continues to be higher in relation to older people (aged 65 and over) than the younger age group (aged 18 to 64), whilst the reverse is the case for all other abuse types.



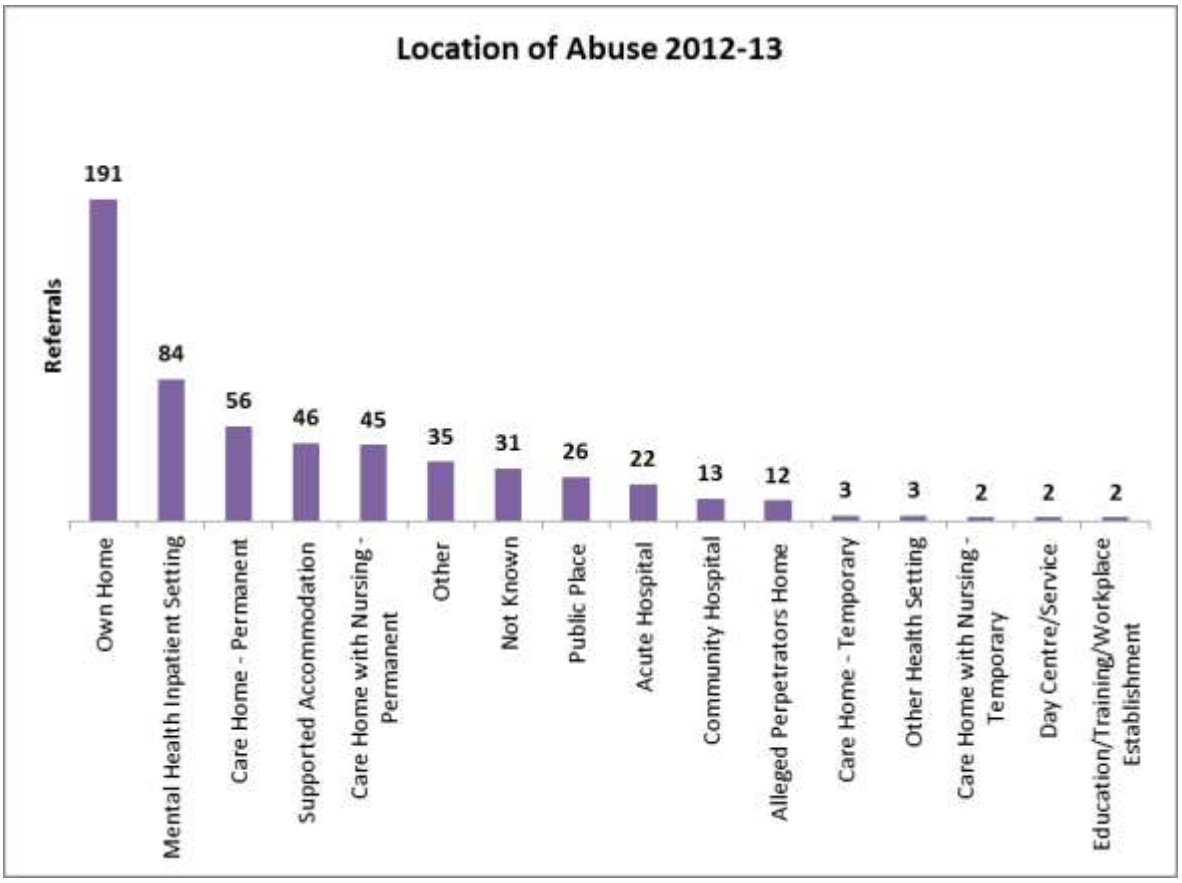

Breakdown of Abuse Type by Gender
Referrals
120
100
80
60
40
20
0
Physical
Sexual
Emotional
Financial
Neglect
Discriminatory
Institutional
Female 118 45 66 69 61 2 3
Male 103 6 34 72 38 0 0


Breakdown of Abuse Type by Age
Axis Title
160
140
120
100
80
60
40
20
0
Physical
Sexual
Emotional
Financial
Neglect
Discriminatory
Institutional
18 - 64 158 41 74 63 27 2 2
65 and Over 63 10 26 78 72 0 1

Location of abuse

The prevalence of abuse in adults own homes (including supported accommodation) continues to be significantly higher than any other setting:

- Reported abuse in adults own homes has reduced from 47% to 41% in the past year
- Reported abuse in health settings has increased from 6% to 22% in the past 3 years and is higher than the average for the London comparator group of boroughs. This includes reported abuse in mental health impatient wards which has increased from 4% to 15% in the past 2 years, reflecting increased awareness and reporting in these settings.
- Reported abuse in residential and nursing homes has slightly decreased from 19% to 18% in the past 2 years and is less than the average for the London comparator group of boroughs. The planned targeting of training and publicity to residents in care and nursing homes may lead to an increase in this reporting field.



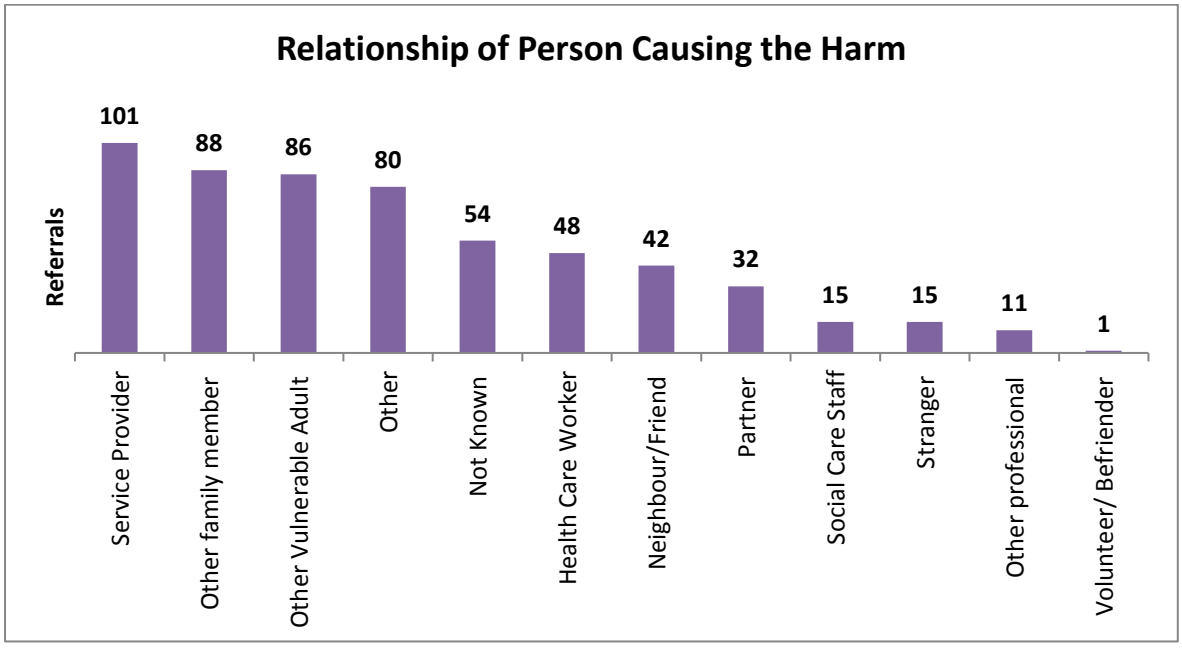
Relationship of person causing the harm

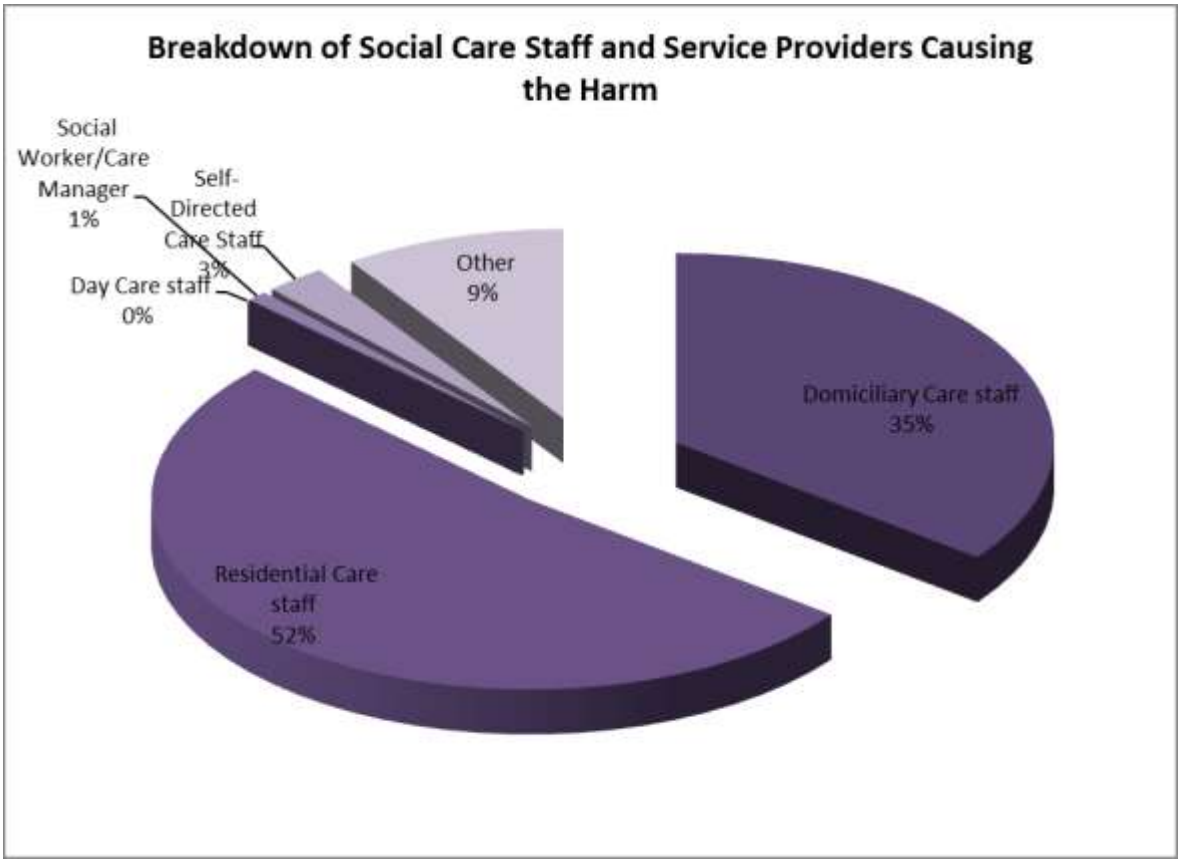
The prevalence of reported adult abuse by an informal contact continues to be significantly higher than that of paid professionals, amounting to 46% against 31% of total referrals (with 23% as unknown or other), compared to 54% and 26% respectively in the previous year.

Informal contacts: The highest reported abuse by informal contacts is by other family members, amounting to 15% of total referrals (compared to 19% in the previous year); as well as by other adults at risk, amounting to 15% for both this and the previous year, compared to an average of 7% in the London comparator group of boroughs. The incidence of abuse by other adults at risk will be covered in a review of practice and recording guidance in the new reporting year.

Formal carers: The highest reported abuse by formal carers relates to service providers, amounting to 10% of referrals relating to residential and nursing staff and 7% to domiciliary care staff.

Health care staff: Reported abuse by health care staff has increased from 4% in the previous 2 years to 8% of referrals this year, the disparity with location of abuse figures suggesting that a significant proportion of reported abuse in mental health inpatient wards is by adults at risk, which will be subject to scrutiny through the improved service provider safeguarding monitoring information that is now available and will be prioritised from the start of the new reporting year.





Referral outcomes

Findings: The number of safeguarding adults investigations resulting in substantiated or partially substantiated findings has remained stable, with a slight increase in not substantiated and a slight decrease in inconclusive outcomes from the previous year, demonstrating a marginal improvement on the proportion of conclusive outcomes. The distribution of findings is broadly similar to the London comparator boroughs, with Wandsworth reporting a slightly higher rate of substantiated and lower rate of not substantiated findings.

A themed audit in the new reporting year will include a review of not substantiated investigation findings to determine whether threshold decisions were proportionate, to contribute to learning and further improved substantiated outcomes as a percentage of all referral findings.

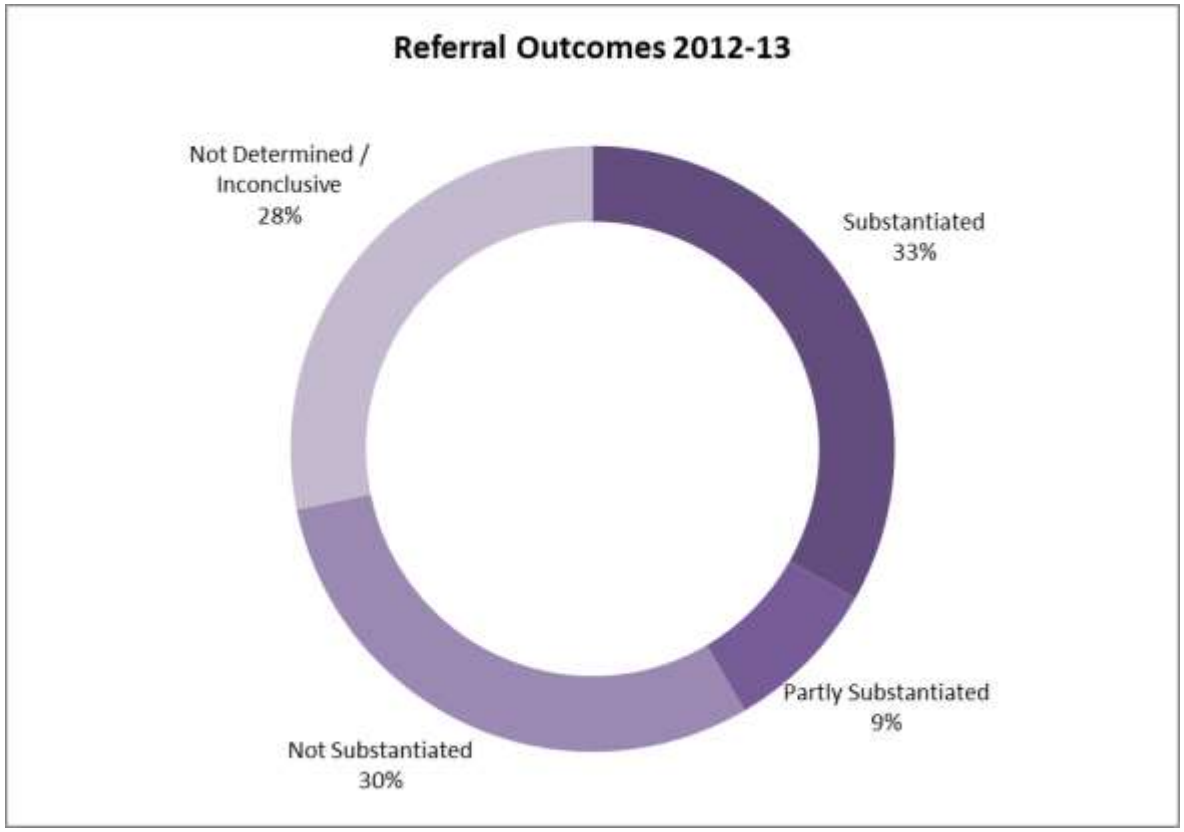
Service area: The Learning Disability and Mental Health service areas continue to report significantly more substantiated than not substantiated and inconclusive outcomes, with a contrasting fairly even spread of findings for Disabilities and Older People. This appears to indicate more decisive judgements in these service areas and will be a focus in the forthcoming themed safeguarding case audits.

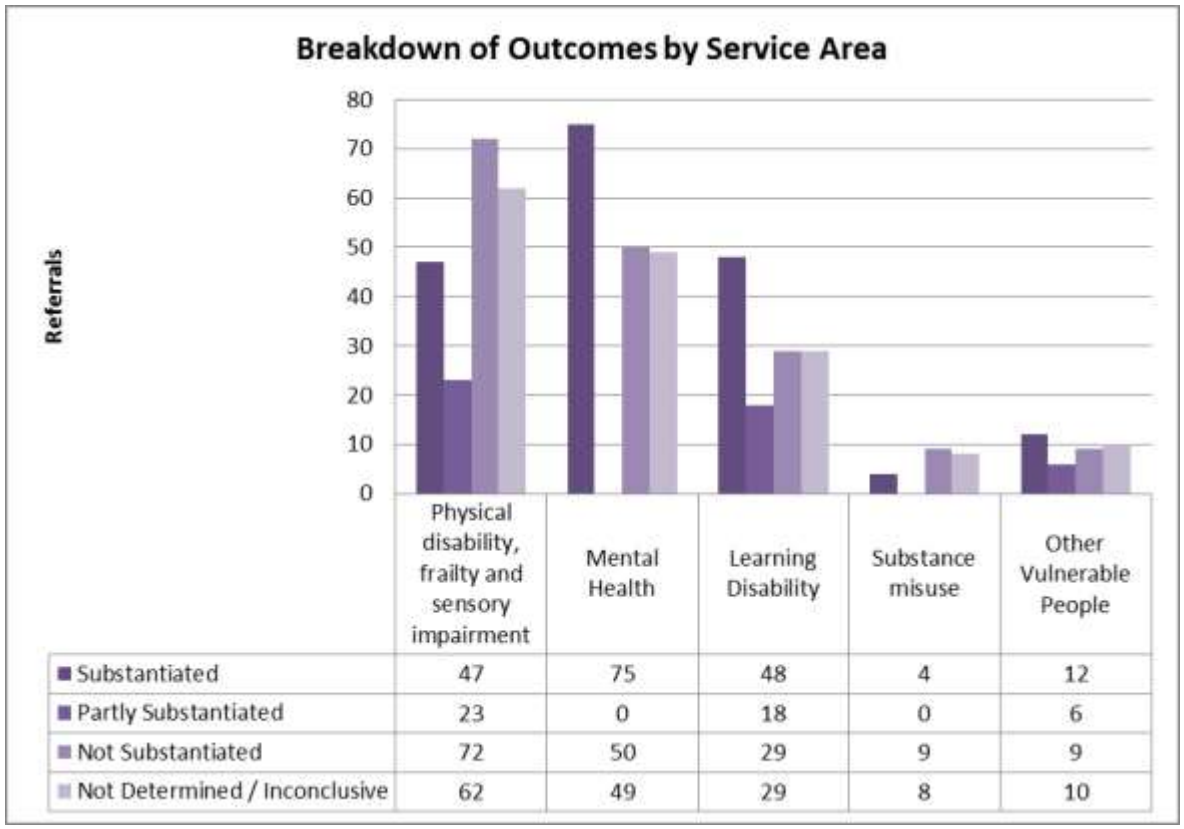
Ethnicity: There are also clear trends in relation to ethnic background and findings, with a significantly higher proportion of white alleged victims of abuse, 46%, resulting in substantiated findings. The proportion of investigations involving Black and Black British alleged victims of abuse leading to substantiated outcomes is 37%. Conversely, for Asian and Asian British alleged victims, only 29% were substantiated, with 44% not substantiated. The possibility of different standards applying to this ethnic grouping will be monitored in the next reporting year.

Outcome for adult at risk: The main recorded outcome for adults at risk is increased monitoring, amounting to 32% compared to 29% in the previous reporting year, although there is a wide range of recorded alternative outcomes. An element of the *Making Safeguarding Personal* initiative in 2013-14 will be a review of person-centred outcomes, including the potential benefit of alternative therapy sessions such as poetry and art workshops.

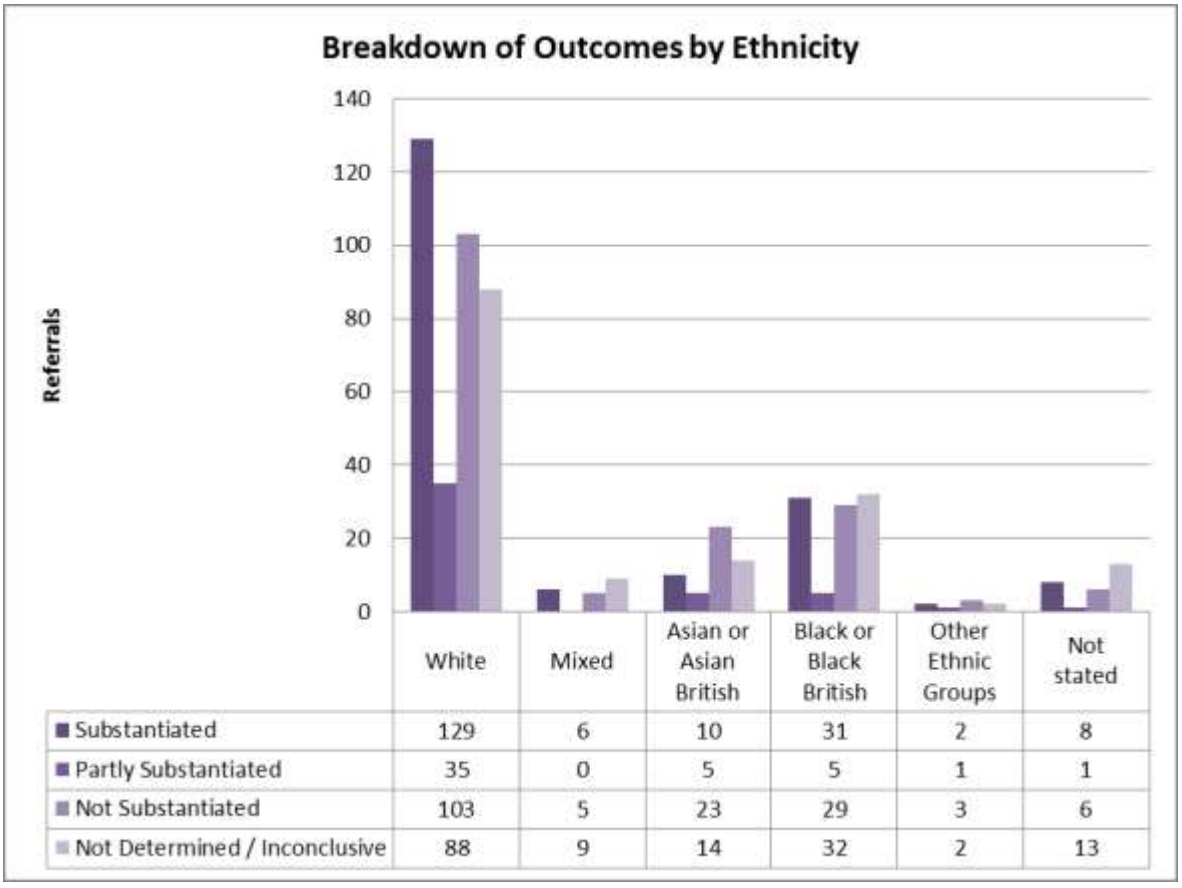
Acceptance of protection plan by adult at risk: Protection plans have been provided in 64% of cases rising to 70% if not substantiated cases are removed. There has been an improvement in the acceptance of protection plans, rising from 73% in 2011-12 to 84% in 2012-13, and is higher than the average for the London comparator group of boroughs. The proportion of adults at risk who did not accept the protection plan fell from 9% to 2%; and the proportion who could not accept fell from 18% to 14% in the same period. In previous years there were notable differences in acceptance of protection plans across service areas, but this year there is a high acceptance rate across all service areas. A more robust recording format has been developed for protection plans developed within strategy discussions, for introduction at the start of the new reporting year.

Outcome for person causing the harm: As in the case of outcomes for adults at risk, the highest recorded outcome for persons alleged to have caused harm is increased monitoring, rising from 18% in 2011-12 to 22% in the current reporting year, although a wide range of alternative outcomes were also recorded.

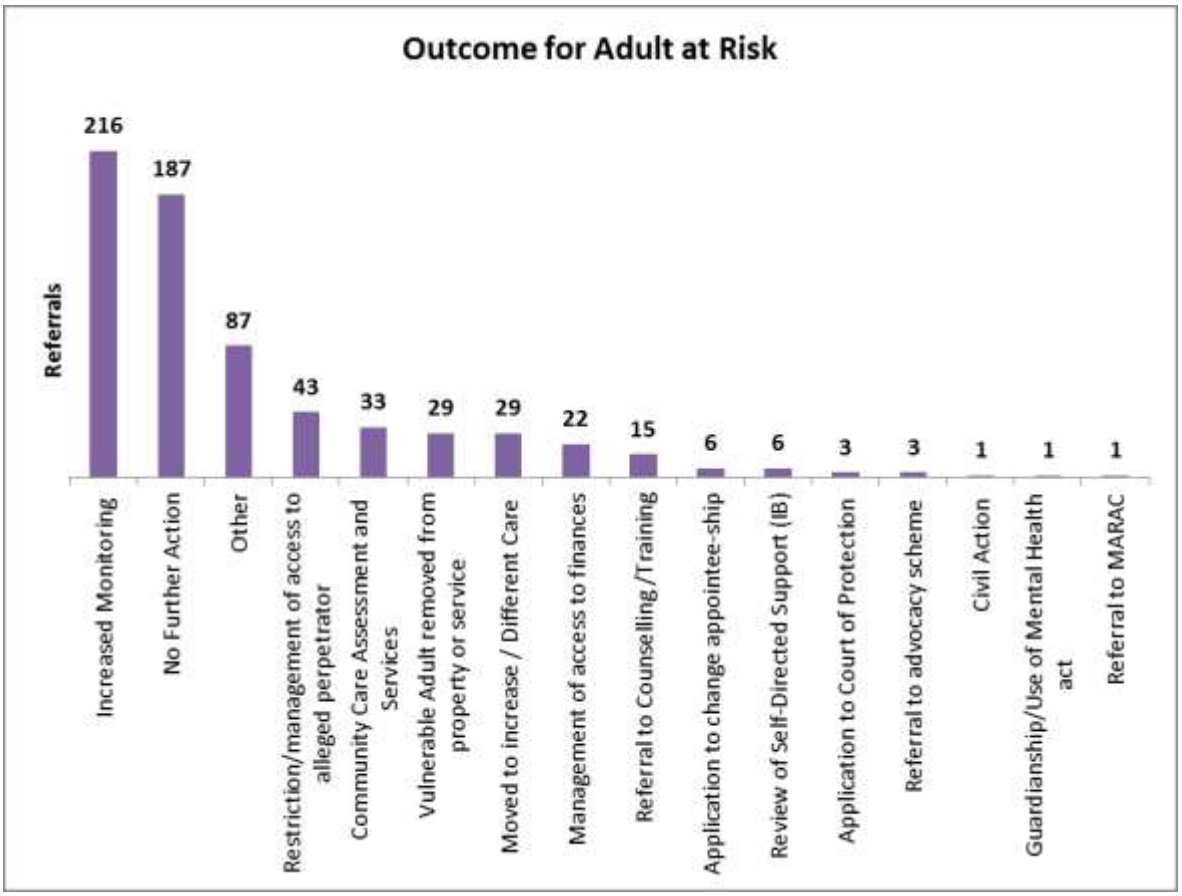




	Physical disability, frailty and sensory impairment	Mental Health	Learning Disability	Substance misuse	Other Vulnerable People
Substantiated	47	75	48	4	12
Partly Substantiated	23	0	18	0	6
Not Substantiated	72	50	29	9	9
Not Determined / Inconclusive	62	49	29	8	10



	White	Mixed	Asian or Asian British	Black or Black British	Other Ethnic Groups	Not stated
Substantiated	129	6	10	31	2	8
Partly Substantiated	35	0	5	5	1	1
Not Substantiated	103	5	23	29	3	6
Not Determined / Inconclusive	88	9	14	32	2	13



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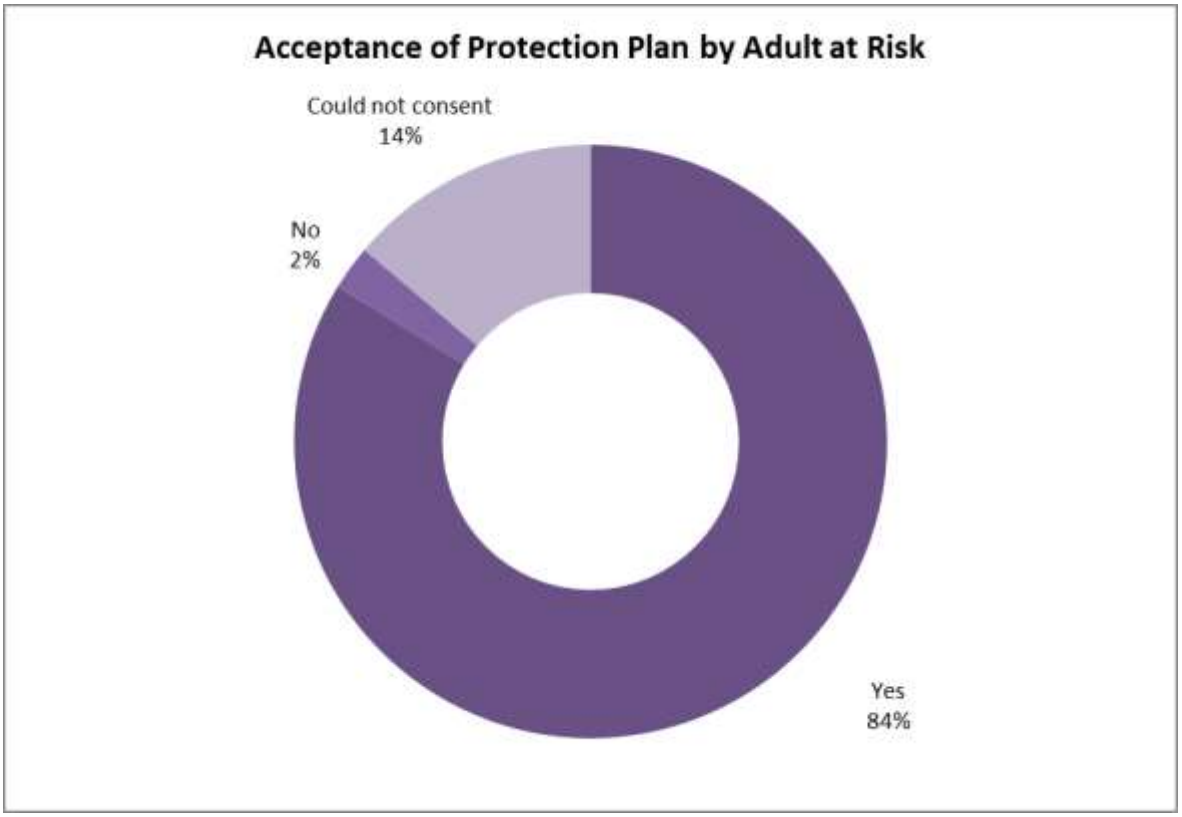
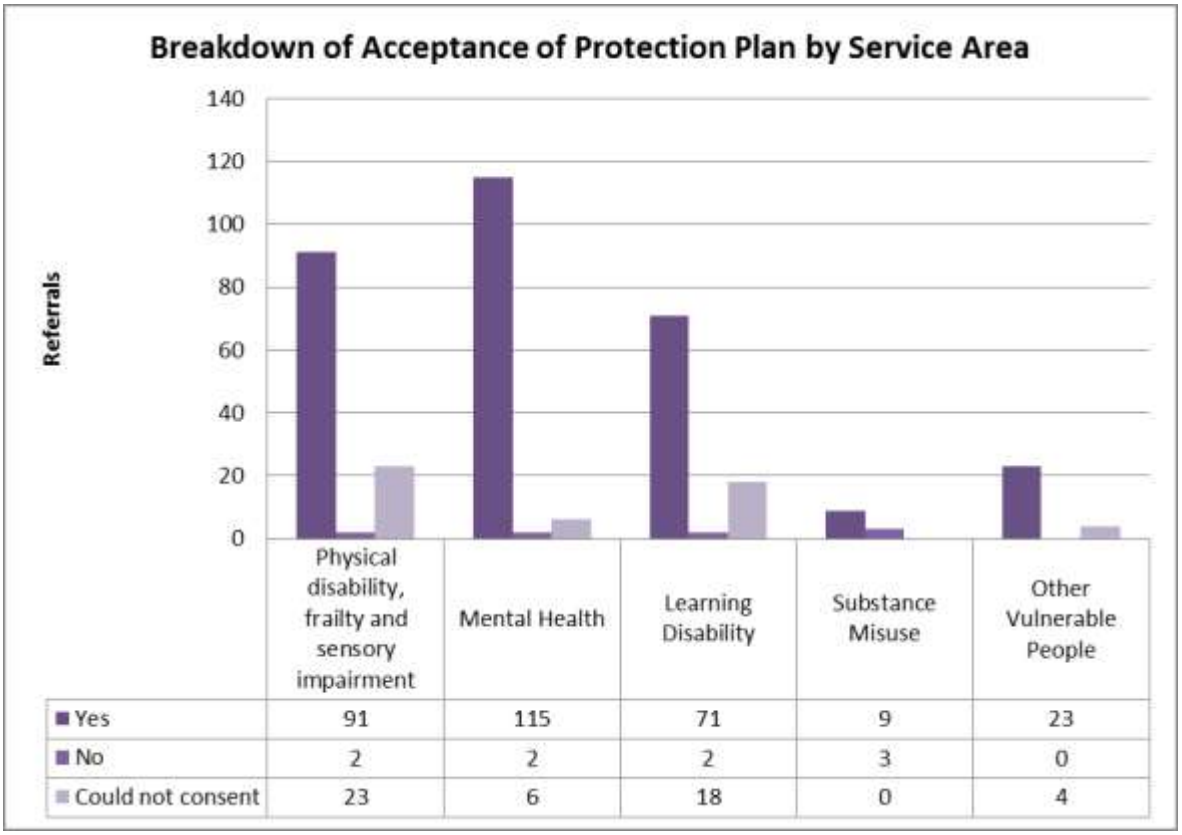
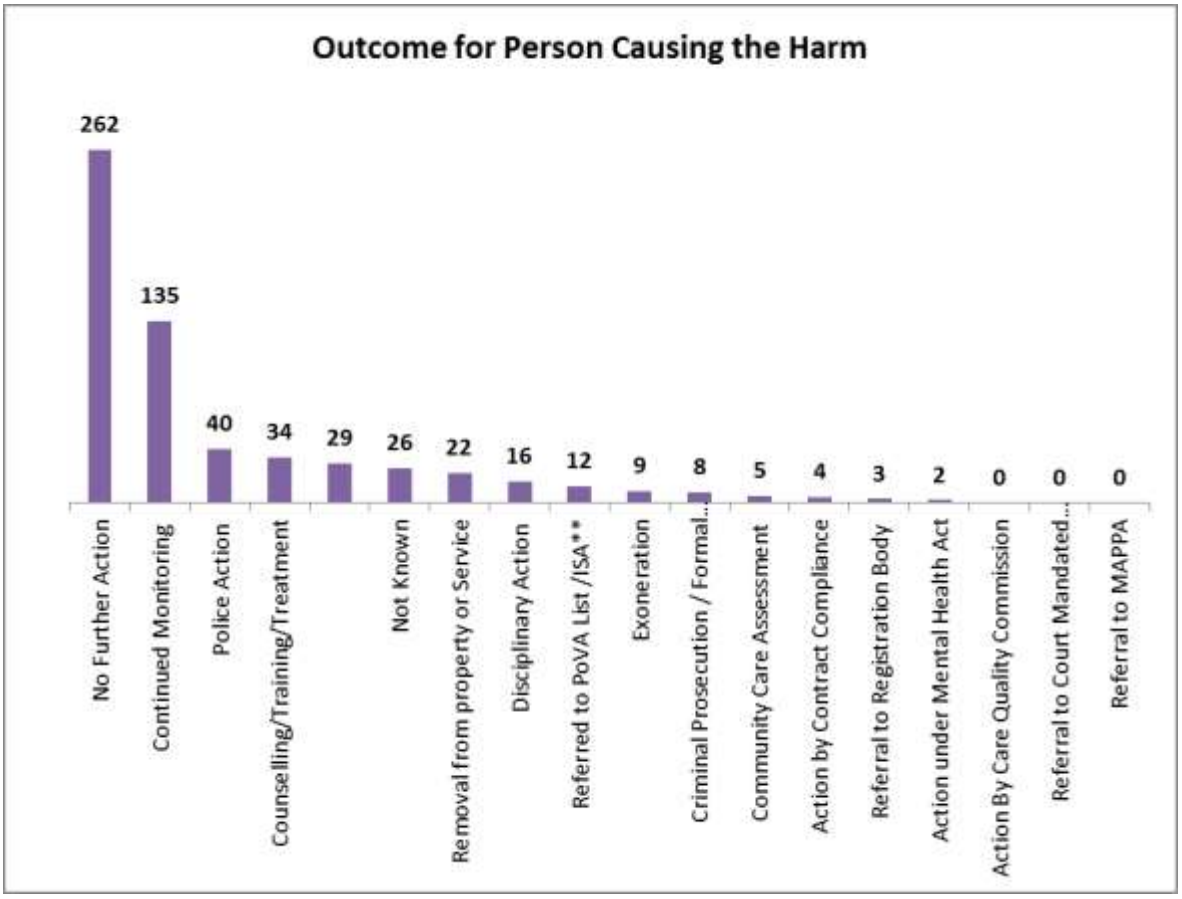

Acceptance of Protection Plan by Adult at Risk
Could not consent
14%
No
2%
Yes
84%


Breakdown of Acceptance of Protection Plan by Service Area
Referrals
140
120
100
80
60
40
20
0
Physical disability, frailty and sensory impairment
Mental Health
Learning Disability
Substance Misuse
Other Vulnerable People
Yes 91 115 71 9 23
No 2 2 2 3 0
Could not consent 23 6 18 0 4



Service level concerns

During the reporting year service level concerns meetings and actions had been undertaken in relation to particular nursing homes and mental health inpatient wards, with improvements evidenced in all of these.

Serious Case Reviews

There were no serious case reviews during the reporting year.

1.6 Training Sub-Group

Core training

A comprehensive Safeguarding Adults training programme was delivered during the reporting year on a similar basis to the previous year, in keeping with required levels of competence and in line with the nationally respected Bournemouth model. The programme was available to Adult Social Services and external agency staff and was commissioned and coordinated by the Safeguarding Adults Team, supported by the Adult Social Services Learning and Development Team, with progress monitored by the Training Sub-Group. Full details of the safeguarding adults training programme are contained in the Board training plan 2012-13.

Core multi-agency training available in the reporting year included:

- Basic awareness and reporting – an e-learning option and Signs and Symptoms to be added in the next reporting year
- Contribution to Investigators training
- Risk Assessment
- Recording

Core mandatory training within Adult Social Services to appropriate staff included:

- Investigators
- Safeguarding Adults Managers

Training was also delivered to Council Members on Safeguarding Adults and Safeguarding Children.

Added value training

In additional to the range of core training courses, the following added value training was provided;

- Adult Social Services and the Mental Health Trust joined with Richmond Adult Social Services and Kingston University to deliver enhanced practice training in the form of a Post Qualification in Safeguarding for Practitioners and Managers. Seven Wandsworth social workers and managers successfully completed the qualification and, following a positive evaluation, there will be a continued commitment to this training next year.

- A programme of Train the Trainer sessions to residential and nursing home managers was commissioned and delivered during the reporting year, with an expectation that cascading to all staff is evidenced. In the new reporting year there will be a commitment to commission basic awareness and reporting training to residents of care and nursing homes and supported housing, as well as day centres, across service areas. This will be accessible to hard to reach residents and will also be in conjunction with a publicity drive.

- Joint basic awareness and reporting training to a range of Council staff, working across children's and adults services, was provided by the Safeguarding Adults Team and Children's Services. To support the review and re-launch in the new reporting year of the joint protocol, *See the Adult, See the Child*, a programme of *Think Family* training sessions will be developed on working with abuse in households involving adults at risk and children.

Training attendance

The training attendance database was improved and updated to provide a more reliable identification of Adult Social Services staff requiring and receiving safeguarding adults training, according to competency requirements. As a consequence, reminders to attend applicable training are sent to line managers. In the next reporting year the database will be further improved to reflect staffing changes as they occur and partner agencies will provide reports on training attendance in line with competency levels. Additional managers and investigators training will be scheduled in 2013-14 to ensure that all appropriate staff have received up to date training.

ASSD Staff Required to attend Safeguarding Training:

	Perm Staff	Agency Staff	Total
Consultant Practitioner	7	*3*	*10*
Manager	19	*4*	*23*
Principal Social Worker	6	*1*	*7*
Senior Social Worker	1	*5*	*6*
SVA Coordinator	2	*1*	*3*
Social Worker	4	*28*	*32*
Social Worker /Senior Social Worker	68	*0*	*68*

Attendance at Safeguarding Training:

	Consultant Practitioner	Manager	Principal Social Worker	Senior Social Worker	SVA Coordinator	Social Worker	Social Worker / Senior Social Worker	Total Attendance	Total Non-Attendance
Risk Assessment & Management In Safeguarding Work	2	4	2	0	0	5	39	52	74
Recording In Safeguarding Work	0	2	1	0	0	5	29	37	89
Safeguarding Adults Investigators	3	4	2	1	1	4	43	58	68
Safeguarding Adults Managers Training	5	12	2	0	1	0	6	26	11

Safeguarding Training (Sep 2013 – Mar 2014):

	Sep	Oct	Nov	Jan	Feb	Mar	Spaces available @ training
Risk Assessment & Management In Safeguarding Work			19th			11th	11
Recording In Safeguarding Work		17th			13th		12
Safeguarding Adults Investigators	4th – 5th	14th – 15th	12th – 13th		4th – 5th	12th – 13th	44
Safeguarding Adults Managers Training		7th – 8th		13th – 14th			19

Practice workshops

Adult Social Services Practice Workshops for all staff and targeted practice workshops for the Community Learning Disability Team were undertaken by the Safeguarding Adults team during the reporting year. Practice workshops will be a Board priority in 2013-14 to ensure consistent practice in safeguarding.

1.7 Publicity Sub-Group

Conference

The Awareness and Publicity Sub-Group coordinated the annual joint initiative with Children's Services to raise public awareness of abuse, with information stands provided across the borough during Safeguarding Week in June 2012. Preparations had also started for Safeguarding week in 2013, including a bi-annual Safeguarding Adults Conference, this year on the theme of learning from Winterbourne View.

Web page

The Board web page was rebuilt during the reporting year, with updated and more accessible safeguarding adults information to staff and the public.

Posters, leaflets and fact sheets

A review of adult abuse awareness material was initiated with printing of updated leaflets, fact sheets, posters and wallet cards planned for a renewed publicity drive in the new reporting year, including information to coincide with residents training.

1.8 Safeguarding Adults and Children's Sub-Committee;

The Safeguarding Adults and Children's Sub-Committee was established in the reporting year to take forward the joint agreed actions of the respective Boards. Key initial achievements included:

- The joint Safeguarding Adults and Children's procedure, *See the Adult, See the Child* has been reviewed during the reporting year and a more robust and clearer procedure will be completed in the new reporting year. This places an emphasis on a Think Family holistic approach to joint prevention, awareness and reporting, and investigation of abuse in households with adults at risk and children.

- Safeguarding adults training now includes reference to the Think Family approach and joint basic awareness training has been provided to staff working across services, including customer services staff.

2. STRATEGIC PRIORITIES 2013-14

Based on the strategic priorities highlighted this year, alongside learning from safeguarding activity and trends, the following Board priorities will be taken forward in 2013-14.

- Strengthening of the strategic effectiveness of the Wandsworth Board through representation by a General Practitioner and Healthwatch.

- Increasing the emphasis on the prevention of abuse, alongside awareness and reporting, through publicity and training that reaches out to the whole community.

- Increasing the emphasis on service user involvement in setting person-centred outcomes in response to abuse, through local development of the national *Making Safeguarding Personal* project and renewal of the Service User Forum.

- Improving consistency in the application of skills across partner agencies in responding to abuse in a timely and proportionate manner, through performance monitoring, auditing, training and workshops

- Building on the response to Winterbourne View, including improving the standardisation and monitoring of care standards through the further development of the Professional and Service Standards Framework, Quality Control Panel, Service Level Concerns protocol and service provider safeguarding activity monitoring.

- Further developing reporting and joint working arrangements with the Police to maximise prosecutions and the availability of justice, through a review of the Police Engagement Protocol and consideration of the role of adults in the local development of a Multi Agency Safeguarding Hub.

- Further developing lead investigator and scrutiny of investigations role, alongside thorough reviews, in the Clinical Commissioning Group and Continuing Health Care.

- Further developing the Safeguarding Adults and Children's Sub-Committee and reviewing the safeguarding models in advance of the amalgamation of Adults, Children's and Education departments in April 2014.

Appendix 1

Safeguarding Adults Partnership Board (SAPB) – Work Plan 2011 - 2014 APPENDIX				
Framework (strategic partnership)				
Objective	**Action**	**Timescale**	**Lead**	**Progress**
1. Review core SAPB membership to ensure seniority and coverage	• Address at SAPB Away Half-Day • Ensure GP, Service User, Citizen, Carers, Fire Service, Prison Service and Probation representation	Oct 2011	Chair of SAPB	Completed
2. Monitor and review Shared Independent Chairing Arrangement and update Terms of Reference	• Address at SAPB Away Half-Day	Oct 2011	Chair of SAPB	Completed
3. Identify annual multi-agency budget to meet 3 year Work Plan in line with agreed training and publicity commitment	• Address at SAPB Away Day	Oct 2011 and ongoing annually	Chair of SAPB	Completed
4. Accountability rests with Director of Adult Social Services	• Annual Report to SAPB and partner agency executive groups	July 2011 and ongoing annually	Director of Adult Social Services	Completed ongoing
5. Partner agencies to report to their Executive Groups	• Partners to submit the SAPB Annual Report to executive boards i.e. Acute Trust Boards, Mental Health Trust Board, etc.	Ongoing annually	SAPB members	Completed ongoing
6. Further strengthen links between SAPB and Boards/ Groups relevant to Safeguarding Adults	• Membership on Safeguarding Children's Board, Community Safety Partnership Operations Group, MARAC, MAPPA, Domestic Violence Forum	Ongoing	SAPB members	Completed
7. SAPB to monitor progress of sub-group actions quarterly	• Sub-group chairs to report progress to SAPB quarterly	Ongoing	Sub-group Chairs	Completed ongoing

Appendix 1

Safeguarding Adults Partnership Board (SAPB) – Work Plan 2011 - 2014 APPENDIX				
Framework (strategic partnership)				
	• Review Terms of Reference	Oct 2011		
8. Further strengthen links to other London Borough Safeguarding Adults Leads to benchmark arrangements	• Contribution to London Safeguarding Adults Network, SW London Safeguarding Adults Leads Cross-Borough Forum, Joint meetings with Richmond Safeguarding Adults Leads	Ongoing	Safeguarding Adults Policy & Development Manager	Completed
9. Further strengthen partnership arrangements with key agency safeguarding leads	• Bi-monthly meetings with Police, Acute Health Trust, Mental Health Trust, Housing re strategic development and monitoring referrals and outcomes	Oct 2011 and ongoing	Safeguarding Adults Policy & Development Manager	Completed
10. Further develop Service User Forum	• Raise awareness of partner agencies to increase membership • Review Terms of Reference	Ongoing	SAPB Service User representative	Completed – requires further development
11. Ensure Council Members appraised of SAPB progress	• Bi-monthly briefings to Council Members	Ongoing	Safeguarding Adults Policy & Development Manager	Completed
12. Further strengthen Safeguarding Adults Team strategic and operational support roles	• Review structure including Case Conference Chairing responsibility	Ongoing	Safeguarding Adults Policy & Development Manager	Completed ongoing
13. Further strengthen commissioning and procurement safeguards to prevent and respond to abuse	• Establish monthly Service Provider Quality Monitoring meetings • Review Service Provider contractual safeguarding requirements, including self-directed support	Oct 2011	Safeguarding Adults Policy & Development Manager	Completed – requires further development
14. SAPB to review Work Plan annually in line with national guidance and possible legislation	• Review and amend 3 year Work Plan	Annually	SAPB Chair	Completed – to develop into updated

Appendix 1

Safeguarding Adults Partnership Board (SAPB) – Work Plan 2011 - 2014 APPENDIX				
Framework (strategic partnership)				
				strategic plan

Safeguarding Adults Partnership Board (SAPB) – Work Plan 2011 - 2014 APPENDIX				
Policy and Procedures Sub-Group				
Objective	**Action**	**Timescale**	**Lead**	**Progress**
15. Implement Multi-Agency Safeguarding Adults Policy and Procedures	• Launch at Annual Conference • Update information on website	June 2011 Aug 2011	Sub-Group Chair	Completed Completed
16. Implement and review updated Wandsworth local procedures (appendices) – including Reporting and Investigation Process, Police Engagement, Medical Evidence, Service Level Concerns, Quality Assurance meetings, Think Family, Self Directed Support, Serious Case Review, VARMM	• Update local procedures • Review local procedures and contribute to review of London-wide procedures, including disclosure without consent, host authority role in investigations and SDS safeguards • Provide briefings direct to operational teams, including clear and consistent thresholds and proportionate levels • Launch Joint Children's Protocol	June 2011 April 2012 April 2012 Oct 2011	Sub-Group Chair	Completed Completed Completed Completed
17. Develop local good practice guidance, including interviewing, repeat abuse by other vulnerable adults	• Develop updated practice guidance	Apr 2012	Safeguarding Adults Policy & Development Manager	Completed – requires updating
18. Develop stand alone Safeguarding (Protection) Plan	• Introduce document to be uploaded with Case Conference minutes	Oct 2011	Sub-Group Chair	Completed

Appendix 1

Safeguarding Adults Partnership Board (SAPB) – Work Plan 2011 - 2014 APPENDIX				
Performance Assessment and Monitoring Sub-Group				
Objective	**Action**	**Time scales**	**Lead**	**Progress**
19. Review Frameworki Safeguarding Adults Workflow to ensure effective reporting	• Project group to review global, agency monitoring, outcomes and case tracking information, to be accessible and in line with national reporting guidelines • Quarterly report to SAPB	April 2012 Nov 2011	Sub-Group Chair	Completed Completed – to be reinstated as part of performance framework
20. Further develop Service User and Informal Carer feedback	• Prioritise feedback forms at Case Conference stage • Quarterly evaluation and actions to SAPB • Develop Informal Carer feedback forms	April 2011 Oct 2011 Oct 2011	Sub-Group Chair	Completed Completed Not completed
21. Implement actions arising from 2010 commissioned practice audits	• Review and monitor Mental Health Trust Safeguarding Improvement Project • Briefing sessions direct to operational teams	April 2011 and ongoing April 2012	Sub-Group Chair	Completed ongoing Completed ongoing

Appendix 1

Safeguarding Adults Partnership Board (SAPB) – Work Plan 2011 - 2014 APPENDIX

Performance Assessment and Monitoring Sub-Group				
22. Implement robust rolling case audit programme and Case Conference themed audit programme	• Update audit tool to concentrate on key areas including thresholds, proportionality, safeguarding (protection) plans • Develop programme of independent case audits and rolling audit workshops, agreeing actions with operational managers and safeguarding adults leads • Develop Case Conference peer borough audits, and internal themed audits including referral thresholds, proportionate responses, user involvement, protection plans and outcomes • Monitor completion of Police and Medical Evidence reports • Monitor Case Conference attendance • Quarterly report to SAPB	Oct 2011 Oct 2011 Oct 2011 Mar 2012 Mar 2011 Oct 2011	Sub-Group Chair	Completed Completed – to be renewed Completed informally ongoing Completed initially – to be refreshed Completed ongoing Completed re initial audits – to be renewed
23. Develop programme of peer reviews with partner local authority	• Implement peer reviews to concentrate on key areas in Case Conference chairing and minuting • Quarterly report to SAPB	April 2012 April 2012	Sub-Group Chair	Not completed As above
24. Review and monitor Serious Case Review Action Plan	• Half-yearly report to SAPB	April 2011 and ongoing	Sub-Group Chair	Completed
25. Review and monitor Equality Impact Assessment in line with Equality Act	• Half-yearly report to SAPB • Improved data collection on	April 2011 and ongoing Mar 2011	Sub-Group Chair	Completed – change in focus Part completed

Appendix 1

Safeguarding Adults Partnership Board (SAPB) – Work Plan 2011 - 2014 APPENDIX				
Performance Assessment and Monitoring Sub-Group				
	protected characteristics			
26. Review and monitor Deprivation of Liberty (DoLS) performance and use of advocacy	• Half-yearly report to SAPB	April 2011 and ongoing	Sub-Group Chair	Reporting completed ongoing – to be regular formal SAPB update

Safeguarding Adults Partnership Board (SAPB) – Work Plan 2011 - 2014 APPENDIX				
Training Sub-Group				
Objective	**Action**	**Time Scales**	**Lead**	**Progress**
27. Ensure all multi-agency staff and volunteers are trained to an appropriate level of competence through mainstream and refresher training	• Annual Training Plan to incorporate level 1 Basic Awareness, level 2 Contribution to Investigations, level 3 Investigators, Level 4 Managers training, Refresher training • Review targeted training • Annual Training Plan to incorporate competency levels • Maintain Adult Social Services Training Database on training attendance • Partner agencies to provide quarterly information on training attendance	April 2011 and ongoing April 2011 and ongoing April 2011 and ongoing April 2011 and ongoing April 2011 and ongoing		Completed Completed Completed Part completed

Appendix 1

Safeguarding Adults Partnership Board (SAPB) – Work Plan 2011 - 2014 APPENDIX				
28. Monitor and review Practice Workshops for multi-agency staff	• Review circulation and content of bi-monthly sessions	Oct 2011	Sub-Group Chair	
29. Provide Train the Trainer sessions to Care and Nursing Home Managers	• Programme of training sessions, covering prevention, awareness and reporting, and evaluation of subsequent training completion	April 2012	Sub-Group Chair	Completed
30. Evaluate effectiveness of training	• Review evaluation forms	April 2012	Sub-Group Chair	Part completed
31. Further develop and Monitor Safeguarding Adults Champions meetings	• Review circulation and content of bi-monthly sessions	Oct 2011	Sub-Group Chair	Not completed

Safeguarding Adults Partnership Board (SAPB) – Work Plan 2011 - 2014 APPENDIX				
Publicity and Awareness Sub-Group				
Objective	**Action**	**Time scales**	**Lead**	**Progress**
32. Annual Safeguarding Adults Awareness Week publicity campaign joint with Children's Services	• Joint information stands in shopping centres • Information stands in local Further Education Colleges	June 2011 and ongoing June 2011 and ongoing	Sub-Group Chair Sub-Group Chair	Completed Completed
33. Bi-annual Conference to coincide with Safeguarding Adults Week	• Conference to launch Policy and Procedures followed by themed Conferences	June 2011 and ongoing	Sub-Group Chair	completed
34. Monitor and review public awareness information	• Review content and circulation of leaflets and posters	June 2011 and ongoing	Sub-Group Chair	Completed

Appendix 1

Safeguarding Adults Partnership Board (SAPB) – Work Plan 2011 - 2014 APPENDIX				
35. Targeted publicity to Care and Nursing Home residents and Sheltered Housing residents	• Distribution of leaflets to all residents and residents/representatives	April 2012	Sub-Group Chair	Scheduled for 2013
36. Review Wandsworth website for Safeguarding Adults	• Updated Policy and Procedures to be available on website • Review all other information on Safeguarding Adults website	June 2011 Oct 2011	Sub-Group Chair Sub-Group Chair	Completed Completed
37. Multi-agency staff questionnaire to establish level of understanding of safeguarding adults arrangements	• Develop and circulate brief questionnaire to staff	April 2012	Sub-Group Chair	Not completed
38. Regular themed articles in Bright Side on awareness of abuse and safeguarding adults arrangements	• Article on Conference followed by bi-monthly articles with case examples	June 2011 and ongoing	Sub-Group Chair	Not completed

Appendix 2

Wandsworth Safeguarding Adults Partnership Board

MEMORANDUM OF UNDERSTANDING

&

SUPPORTING ANNEXES

Appendix 2

Wandsworth Safeguarding Adults Partnership Board

1. PURPOSE

The Memorandum of Agreement provides the framework for setting out roles, responsibility, authority and accountability of the statutory agencies who are represented on the Board. It enables the Board to develop mechanisms for policies, strategies and thresholds, to give guidance and ensure freedom from discrimination.

The purpose of this Memorandum of Agreement [MOA] is to ensure that partner agencies of the Wandsworth Safeguarding Adults Board [WSAPB]:

- Have a clear vision and shared agreement of its purpose and the expected outcomes for safeguarding adults in vulnerable situations in Wandsworth ;
- Deliver national and locally agreed priorities and secure expected outcomes;
- Understand arrangements for accountability and responsibility for operation and safeguarding outcomes;
- Commit to the development of a 3 year strategy supported by an annual Business Plan;
- Assess and manage risks in relation to agreed business plans and stated objectives and outcomes;
- Monitor delivery and performance against agreed plans, priorities and best practice standards;
- Are empowered to carry out the remit of safeguarding Adults in vulnerable situations;
- Provide relevant information on performance and outcomes as required, in order to develop a basis for evaluation and scrutiny of progress and performance.
- Embrace continuous learning across agencies

2. PRINCIPLES

All partner agencies agree to subscribe to the following guiding principles in relation to safeguarding vulnerable adults:

- **Actively work together** within an inter agency framework based on “No Secrets” and Pan London guidance and relevant best practice and government guidance;

- **Actively promote** the empowerment and well being of vulnerable adults through the services they provide;

- **Act in a way which supports the rights of the individual** to lead an independent life, based on self determination and personal choice, which is free from abuse and neglect.

- **Recognise people who are unable to take their own decisions** and/or protect themselves, their assets and bodily integrity;

- **Recognise that the right to self determination can involve risk** and ensure that such risk is recognised and understood by all concerned, and minimised whenever possible [there should be an open discussion between the individual and the agencies about the risks involved to him or her];

- **Ensure the safety of adults in vulnerable situations** by integrating strategies, policies and services relevant to abuse within the framework of legislation [that is available to do so];

- **Ensure that when the right to an independent lifestyle and choice is at risk the individual concerned receives appropriate help,** including advice, protection and support from relevant agencies; and,

- **Ensure that the law and statutory requirements are known and used appropriately** so that adults in vulnerable situations receive the protection of the law and access to the judicial process.

The Wandsworth Safeguarding Adults Partnership Board represents a joint working arrangement where the partners:

- Agree to work together to achieve common goals and outcomes for local people;
- Share accountability, risk and resources appropriately;
- Set up organisational arrangements with agreed multi and single agency processes and procedures.

The work of the Board is also underpinned by other general sets of principles to which all agencies agree to subscribe:

- Nolan [Annex 2]
- Partnership [Annex 3]
- Caldicott [Annex 4]

3. TERMS OF REFERENCE

These will be formally considered and approved by the Wandsworth Safeguarding Adults Partnership Board and be subject to regular review or update.

4. ACCOUNTABILITY

Accountability for leading the creation and maintenance of the Safeguarding Board is clearly located with the Local Authority, designated to the Director for Adult Social Services for Wandsworth and Richmond

Each agency has specific responsibility for ensuring their services and functions are discharged having regard to the need to safeguard and promote the independence, health and well-being of adults who may be vulnerable to abuse and neglect.

Each agency agrees to ensure effective and consistent representation on the Board by nominating representatives of appropriate seniority. All Board members will be key

delivery partners able and determined to work within and deliver the outcomes intended to arise from the Board's remit. They will remain accountable to their agency and the Board on all relevant matters impacting on outcomes for adults who may be vulnerable to abuse and neglect.

The Board is accountable for its work to its constituent agencies through the appropriate Scrutiny Committees of Wandsworth Council and to the respective Local Strategic Partnerships. Board members are accountable to their own organisations, and to the Board within the remit of the stated roles and responsibilities.

5. GOVERNANCE – NOMINATED MEMBERSHIP [Partners]

All Members nominated to serve on the Board will receive a formal letter confirming their appointment and its term from the Director of Adult Social Services. Nominating bodies may change their nominee at any time in writing to the Director of Adult Social Services. Every effort will be made to secure protected time for Board Members within their primary agency role.

Full membership of the Board may be amended as it identifies other persons and bodies who are exercising functions or engaging in activities relating to safeguarding of adults with whom they consider arrangements should be developed and where this would facilitate strategic leadership and direction. All such arrangements are subject to confirmation by the Director of Adult Social Services on the recommendation of the Board through its Chair.

6. ROLES AND RESPONSIBILITIES OF BOARD MEMBERS

6.1 Members of the Board are required to contribute to the WSAPB's objectives and responsibilities as set out in the Terms of Reference. In order to fulfil this obligation WSAPB Members will:

Be a named person representing their agency who:

- Can speak for their organisation with authority;
- Can commit to reporting from and back to their organisation;
- Will ensure their organisation adopts agreed multi-agency policies, procedures and practices;
- Can ensure that decisions made by the WSAPB, which affect their agency are addressed within their agency and that policies and procedures are adhered to.

Commit to their involvement in the work of the WSAPB to achieve consistency and continuity by:

- Attending 100% of WSAPB meetings and, where she/he is not available to attend, ensuring a named substitute who has delegated responsibility to act on behalf of the nominee attends;
- Chairing a WSAPB group as required;
- Facilitating the involvement of staff from their agency in the work of WSAPB groups as agreed;

- Bringing strategic of significant safeguarding issues to the attention of the WSAPB as appropriate;
- Contributing to the assessment of performance and recommending ofdeciding upon necessary steps to put right any problems.

7. EQUALITIES AND INCLUSION

The partnership will operate and actively value the benefits of diversity and ensure fair treatment and equality of opportunity. An equality impact assessment will be undertaken and reported to the Board within 12 months of its operation. Information on safeguarding will include appropriate information, subject to availability, on gender, disability, age, sexual orientation, faith or belief and ethnicity.

8. RESOURCES

Statutory agencies who are members of the Board will make appropriate contributions of resources. The annual budget will be agreed by the Board, who will agree on appropriate mechanism for allocating the budget based on priorities in the Business Plan. The local authority will ensure appropriate accounting of finance and will manage relevant contracts for employment or service by agreement.

9. DISPUTES

In the event of a dispute arising between agencies, which cannot be resolved, the WSAPB independent chairperson will consider the matter and determine an appropriate course of action. This will generally involve representatives on the Board, and the Chief Officer of the agencies concerned.

10. TERMINATION & VARIATION

The commencement date for this memorandum of understanding is 23.04.13

The Board will consider the need for alteration and review each year at its Annual Business Meeting. Proposed changes shall be made in consultation with the Director of Adult Social Services except in the case of the following:

- Membership of Working Groups [Board responsibility]
- Working Group Forward Plans [Board Responsibility]

Appendix 2

ANNEX 1

NOMINATED BOARD MEMBERSHIP 2013 – 2014 (PARTNERS)

Agency	Position Held	Name
Care Quality Commission	N: Compliance Manager	Tony Allen
	S:	
SWLSTG Mental Health NHS Trust	N: Lead Social Worker	Mark Barnard
	S:	
Equalities Working Group	N: Service User	Colleen Bowen
	S:	
Balham Park Surgery	N: General Practitioner	Dr Patrick Bower
	S:	
St George's Hospital	N: Deputy Director of Nursing	Vikki Carruth
	S:	
Family & Community, Children's Services	N: Service Manager	Debbie Eaton
	S:	
Wandsworth Clinical Commissioning Group (CCG)	N: Deputy Clinical Governance (NHS111/ OOHs) & Adults Safeguarding Lead	Colin Edwards
	S:	
St George's Hospital	N: Safeguarding Lead	David Flood
	S:	
Wandsworth CCG	N: Associated Director Quality, Innovation & Clinical Governance	Evonne Harding
	S:	
Alzheimer's Society	N: Support Services Manager	Donna Johnson
	S:	
Housing Department, Wandsworth Borough Council (WBC)	N: Head of Housing Strategy & Development	Chris Jones
	S:	
ASSD, Richmond Council	N: Director	Cathy Kerr
	S:	
Metropolitan Police	N: Head of CSU & PPD	DI Darrell Knowles
	S:	
Technical Services Department, WBC	N: Head of Community Safety	Stewart Low
	S:	
WBC	N: Cabinet Member of Adults Social Services	Cllr Maddan
	S:	

N: = nominee **S: = Substitute**

Appendix 2

NOMINATED BOARD MEMBERSHIP 2013 – 2014 (PARTNERS)

Agency	Position Held	Name
WBC	N: Assistant Director of Environment & Community Services	Paul McCue
	S:	
VoiceAbility	N: Advocate	*Paul Morley*
	S:	
Department for Works and Pensions	N: Partnership Support Manager	Colin Morris
	S:	
Specialist Services, Mental Health NHS Trust	N: Service Director	Peter Nash
	S:	
Wandsworth Safeguarding Children's Board	N: Development Manager	Anji Reynolds
	S:	
London Fire Brigade	N: Station Manager	Peter Rickard
	S:	
Safeguarding Adults, WBC	N: Policy & Development Manager	Clive Simmons
	S:	
Operations, Adults Social Services Department (ASSD), WBC	N: Assistant Director	Kerry Stevens
	S:	
Battersea Fire Station, London Fire Brigade	N: Firefighter	Jack Storey
	S:	
ASSD, WBC	N: Head of Policy & Performance/Equalities Representative	Sandra Storey
	S:	
Wandsworth Probation Services	N: Assistant Chief Probation Officer	Mike Terry
	S:	
Service User Forum	N: Service User	Veronica Thomas
	S:	
Wandsworth Carers; Centre	N: Director	Eglionna Treanor
	S:	
Wandsworth, Mental Health NHS Trust	N: Service Director	Jeremy Walsh
	S:	
ASSD, WBC	N: Director	Dawn Warwick
	S:	
Wandsworth	N:	Mark Whyment
	S:	

N: = nominee S: = Substitute

ANNEX 2

NOLAN [PRINCIPLES OF PUBLIC LIFE]

The Nolan Committee on Standards in Public Life [1996] identified seven principles to guide those in public positions. They were:

Selflessness

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

Holders of public office should promote and support these principles by leadership and example.

Appendix 2

ANNEX 3

GENERAL PRINCIPLES OF PARTNERSHIP WORKING

The principles of how best to work together have been considered and all the Board Members will seek to work in such a way as to:

- Focus on clear and agreed outcomes for people.
- Promote mutual trust and respect for roles.
- Offer clear purpose, priorities and deliverables.
- Ensure effective decision making and realism on delivery.
- Demonstrate shared commitment and ownership.
- Secure effective communication and accountability.
- Use combined expertise to deliver more.
- Manage and share risks.
- Ensure inclusion, involvement and linking to others.
- Pursue mutual learning, challenge and benchmarking with the best.
- Identify mechanisms for monitoring and reviewing performance, progress and success and for policy and service audit and assurance.
- Agree appropriate use and sharing of resources.
- Promote consistency in membership and attendance.

Appendix 2

ANNEX 4

THE CALDICOTT PRINCIPLES

In applying Safeguarding principles agencies may need to balance the requirements of confidentiality with the consideration that, to protect vulnerable adults, it may be necessary to share information consistent with the Caldicott principles outlined below:

Formal justification of purpose

Information transferred only when absolutely necessary

Only the minimum required

Need to know access controls

All to understand their responsibilities

Comply with and understand the law

SAFEGUARDING ADULTS PARTNERSHIP BOARD
AWARENESS AND PUBLICITY SUB-GROUP

COMMUNICATIONS PROTOCOL

This Protocol is designed to ensure that the SAPB can respond, when necessary, as a single entity to any high profile issues likely to attract public/media attention. The Protocol also seeks to ensue that any such response is made while taking into account the separate response of any individual member organisation of the SAPB.

1) On learning of any potentially high–profile issue, the relevant Partnership member shall notify i) the Chair of the SAPB; ii) WBC'S Director of Adult Social Services and Policy & Development Manager – Safeguarding Adults; iii) the WBC Press Office (who will act on behalf of the SAPB in terms of media briefings, press releases etc); iv) their own organisation's management and Press/Publicity staff as relevant.
2) The WBC Press Office shall, in liaison with the notifying Partnership member, draft an SAPB position statement and any supporting material, this will be for agreement by the Chair of the SAPB and WBC's Director of Adult Social Services and Policy and Development Manager – Safeguarding Adults.
3) The notifying Partnership member shall also provide the WBC Press Office with the draft of any position statement that the member wishes to release in its own right. It is recognised that that the WBC Press Office, on behalf of the SAPB, may comment on such a draft, but that it is the prerogative of the Partnership member to issue its own statement.
4) Where further action is required, e.g. press conferences, formal investigations, serious case reviews etc, the WBC Press Office shall act on behalf of the SAPB and will continue to liaise with the Press Office/relevant staff or the Partnership member.

V1/25.3.13/PM