Wandsworth Safeguarding Adults at risk

Wandsworth Safeguarding Adults Board
Annual Report 2014/15

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1 Welcome from the Chair

I am pleased to present the Annual report of the Wandsworth Safeguarding Adults Board (SAB) for 2014/15. The Board is required to report on progress against our priorities from the last year and look forward and plan our priorities for the future year. This annual report demonstrates how we have made a difference to safeguarding adults at risk in Wandsworth during the last year.

I have now been in post as the independent chair of the Wandsworth Safeguarding Adults Board (SAB) for a year. This has been an interesting year with many significant changes, as the SAB embraces the challenge and opportunity provided by the Care Act 2014, which was implemented nationally in April 2015. Working together has never been so important, as we continue to test and hold partner agencies to account for making a positive and real difference to people's lives. The profile of adult safeguarding continues to improve and engagement in and contribution to this area of work by all agencies is increasing.

The Board has delivered a clear vision in line with Phase 1 of the Care Act about how we will further improve safeguarding across agencies so that adults at risk are able to live free from abuse and with improved wellbeing. Safeguarding Adults Boards now have statutory duties and powers to work in partnership, to complete safeguarding enquiries in response to suspected abuse and neglect, and to undertake safeguarding adults reviews of multi-agency practice. These will be further explained in this report. In preparation the board had commissioned an independent review of the effectiveness of the Board in performing its strategic functions and we have been implementing and monitoring our progress against this during the year. Progress in meeting these recommendations is covered in this report in achieving improved practice and outcomes for service users, both in terms of their safety and well-being.

We have met many of the objectives we set as a Board and there are clear examples of improvements. There is stronger Board oversight and Care Act compliance; with safe, proportionate and personalised enquiries; successful audits; a better trained workforce and a more informed local community. However, we recognise there is still more to do.

We have undertaken one Safeguarding Adults Review this year, which will be covered in this report, and the challenge has been to embed the learning from this into improved practice; including improved risk management arrangements to prevent abuse through introducing a Vulnerable Adults Risk Management Meeting (VARMM) initiative and a Community Multi-Agency Risk Assessment Panel (CMARAP); both of which will be detailed in this report.

In 2015-16 we will do more to achieve our vision by refocussing on our key roles and objectives:

- A Safeguarding Adults Board that works in partnership to oversee an effective safeguarding adults service in the borough
- Safe, proportionate and personalised safeguarding adults enquiries in response to the suspected abuse and neglect of adults at risk
- Effective risk management to prevent abuse and in response to self-neglect
- Effective response to concerns about service providers and prevention of abuse and neglect by working with service providers to promote dignity
- Effective deprivation of liberty safeguards to ensure that adults at risk who lack mental capacity do not have unreasonable constraints placed on their freedom
- Clear and transparent quality assurance and performance monitoring to show that safeguarding outcomes are safe, proportionate and personalised
- A multi-agency workforce that is equipped with the skills to prevent, report and respond to abuse and neglect
- Active engagement with the local community to ensure that the safeguarding service is responsive to the needs and aspirations of people in the borough.

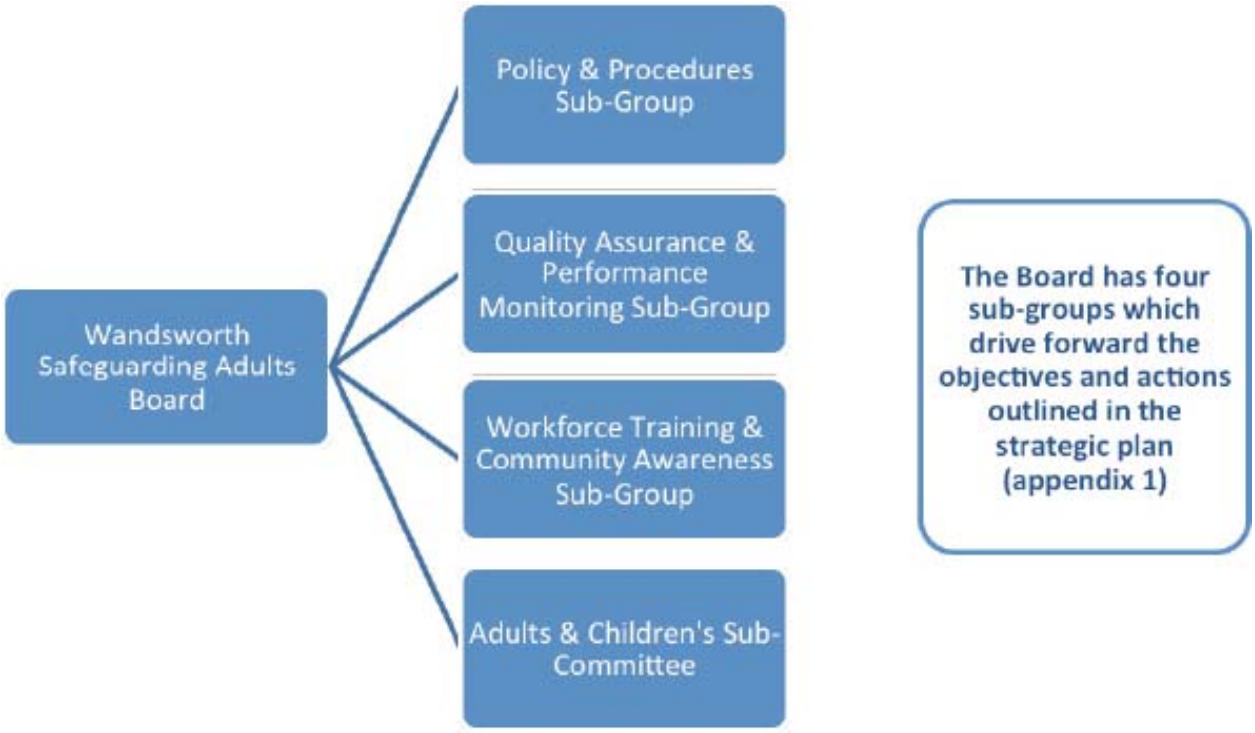
Finally I would like to acknowledge that championing adults at risk requires a culture, across all agencies, where staff are open to challenge and new ideas. That ethos has again been tested this year. I am privileged to work with partners who are open and willing to analyse their performance to ensure it improves outcomes for adults at risk. I would like to thank members of the Board for their work during this reporting period and particularly all the frontline practitioners and managers in Wands-worth for their dedicated work in safe-guarding adults at risk. We will continue to seek out what we can do better, to support the community we serve and to work together with adults at risk and the local community.

Nicky Pace

Independent Chair
Wandsworth Safeguarding Adults Board

2 Who we are and what we do?

From April 2015 the Board has taken on statutory duties and powers invested by the Care Act 2014. The statutory Board members are the Local Authority Department of Education and Social Services, the Clinical Commissioning Group and the Police. The Board has a responsibility to oversee an effective multi-agency safeguarding adults service in the borough, with a clear vision that all adults at risk are able to live free from abuse and with improved wellbeing. It has specific responsibilities to produce and monitor the successful implementation of an annual strategic plan; to complete safeguarding adults reviews when appropriate; to carry out safeguarding adults enquiries in response to abuse and neglect, or to cause other agencies to carry out enquiries; and to prevent abuse and neglect.



Wandsworth Department of Education and Social Services, as the lead coordinating agency, has continued to invest in a Safeguarding Adults Team to support safeguarding adults work in the borough. The team provides a wide ranging safeguarding service, including consultation to managers and practitioners across agencies; chairing and minuting safeguarding meetings; and coordinating some safeguarding enquiries alongside those addressed by social work teams.

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

If you think that you could assist the Board in its work in any way, please contact the Wandsworth Council Safeguarding Team: **safeguardingadults@wandsworth.gov.uk**

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

3 Safeguarding in numbers

It is evident that many of the safeguarding adults trends reported in previous years have continued this year. This section will highlight some of the key trends and how these will inform the objectives and actions for next year, which are detailed later in this report.

There has been a reduction in the number of referrals and in those progressed as safeguarding enquiries (table 1 page 9), reflecting an increased focus on safe and proportionate responses through more rigorous application of eligibility thresholds.

There has been no change in the thresholds for addressing safeguarding referrals and there is a proactive early response. On receipt of referrals which do not meet the threshold for a formal safeguarding response, due to the person not being an adult at risk or that there are not grounds to suspect abuse, alternative responses are considered if necessary.

This is in direct response to the findings of a commissioned audit of safeguarding adults practice in Wandsworth in 2014; that practice is safe and personalised, but that eligibility thresholds were not applied rigorously enough, leading to safeguarding responses when alternative responses were more appropriate. It is also in response to the Care Act, which necessitates clear eligibility decisions. Internal auditing has shown that referral decisions continue overall to be safe and are proportionate. Continued auditing will be a priority to ensure safe, proportionate and personalised enquiries, alongside training and staff briefings.

There continues to be a higher proportion of referrals of adults in mental health inpatient wards than in London generally, due to the location of a large mental health hospital in the borough, although the proportion of total referrals has reduced. This may be due to the increased emphasis on raising standards through training and provider concerns responses, or may be due to under reporting. The number of referrals of people with mental health concerns has an effect on general reporting figures in the borough, including age range, support reason and place of alleged abuse (tables 2 page 9, 3 page 10, 6 page 11). There will be a continued emphasis on monitoring and supporting safe practice in mental health inpatient wards, including training.

There is a continued reduction in the proportion of Black/Black British people represented in referrals (table 4 page 10), which may indicate under reporting. This trend will continue to be monitored and will be a focus in an increased emphasis on community engagement.

Quality Assurance

There has been a continued emphasis on quality assurance to ensure continuous improvement in prevention of abuse; and safe, proportionate and personalised outcomes to safeguarding enquiries in response to abuse. In addition to internal auditing of practice, two large externally commissioned audits were conducted by the Department of Education and Social Services in March 2014 and June 2015, with a focus on multi-agency working. The key findings are outlined below.

2014 Audit

- Overall practice was safe and timely actions were taken to protect adults at risk, although some delays occurred – with practice in 81% of cases considered to be good or adequate
- The threshold for referrals and referral decisions is low, with safeguarding not always the most appropriate response
- There was evidence of effective multi-agency work, with scope for further improvement of communication between agencies in conducting enquiries

2015 Audit

- Good, safe, proportionate practice with management oversight is evident - with practice in 95% of cases considered to be good or adequate
- All cases showed evidence of personalised practice and a focus on wellbeing; adults at risk and family representatives interviewed expressed overall satisfaction
- Further development of best practice can be enhanced by an increased range of multi-agency training opportunities and reflective practice discussions at an operational level

Results

In response to the 2014 audit, an improvement plan was put in place. This included a range of measures, including strengthened management oversight and threshold decisions, improved guidance on personalised practice, improved risk management arrangements to prevent and respond to abuse, improved joint working arrangements, improved training opportunities, and the development of practice workshops.

The improvement plan has been updated in response to the 2015 audit to ensure continuous practice improvement in preventing abuse and in providing safe, proportionate and personalised enquiries.

3 Safeguarding in numbers

There is a continued low level of referrals relating to domiciliary care (tables 5 page 11, 7 page 12) and this will be a priority area in terms of training in basic awareness and reporting.

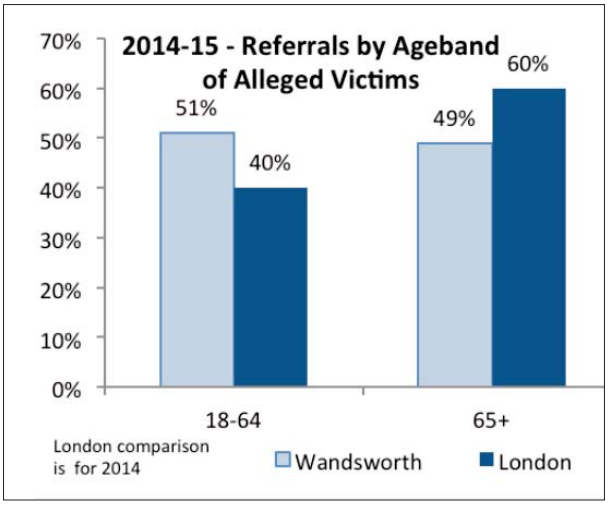
There continues to be a lower, although increasing, number of referrals relating to people in care and nursing homes (table 7 page 12), which may reflect under reporting in this area. The figure may also in part explain the lower than London average proportion of alleged neglect referrals (table 6 page 11). This trend will be met by an increased emphasis on abuse awareness and dignity training in care homes.

There are a low and reducing number of repeat referrals in Wandsworth (table 8 page 12). This may be directly related to a significant increase in the number of safeguarding cases resulting in safeguarding actions, and in reduced or removed risk (table 10 page 13), which is ahead of the London average. The trend can be explained by an increased emphasis on safe, proportionate and personalised enquiries.

In contrast, there is a decrease in the proportion of substantiated outcomes and an increase in the proportion of not substantiated outcomes (table 9 page 13) which, unlike the previous year, is slightly behind the London average. It is expected that the increased emphasis on tightening decisions on eligibility will lead to a higher proportion of substantiated outcomes, and this will continue to be monitored, alongside an emphasis on training and staff briefings.

Making Safeguarding Personal is a new reporting field and initial figures show that three quarters of outcomes desired by service users were met or partly met (table 10 page 13). There are a number of reasons why desired outcomes are not met and this will be subject to continued monitoring and auditing, alongside training and staff briefings, to ensure that safeguarding is personalised.

Table 1

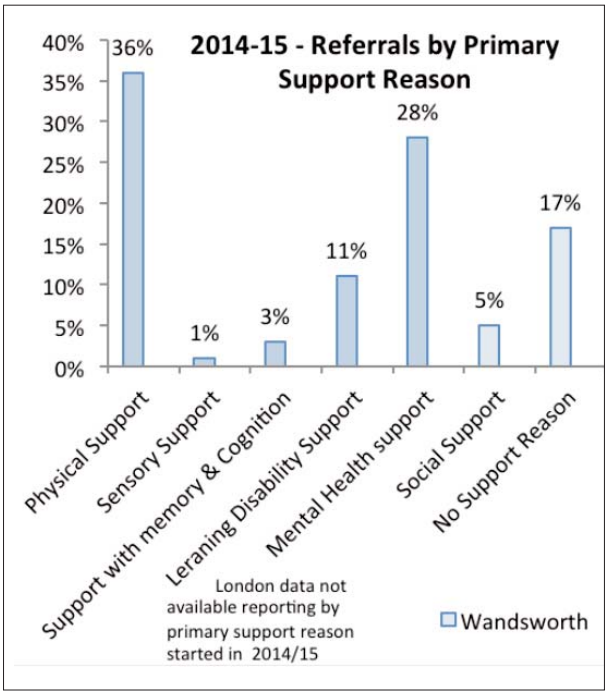


Referrals broken down by age band continue to show that the proportion of people aged 18-64 in Wandsworth who are subject to a referral is balanced with those aged 65+, in contrast with the wider London trend of a higher proportion of people aged 65+.

This is in part explained by the higher number of mental health service users in Wandsworth than in London generally, due to the location of a large mental health hospital in the borough. Within the 18-64 age band of alleged victims outlined here, 45% of people have a primary support reason of mental health support.

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

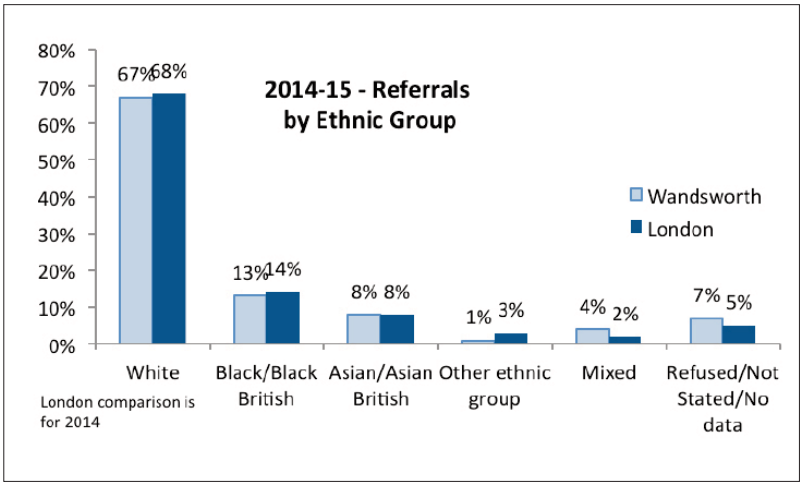
Table 2



This is a continuation of the reporting field introduced in the previous year, with the focus on the primary support needs of people, rather than on a category applied to the individual.

Mental Health referrals continue to be high but have reduced significantly from the previous year (40%), reflecting a reduced referral rate from mental health hospital inpatient wards. The aforementioned mental health hospital accounted for 11% of the total referrals progressed.

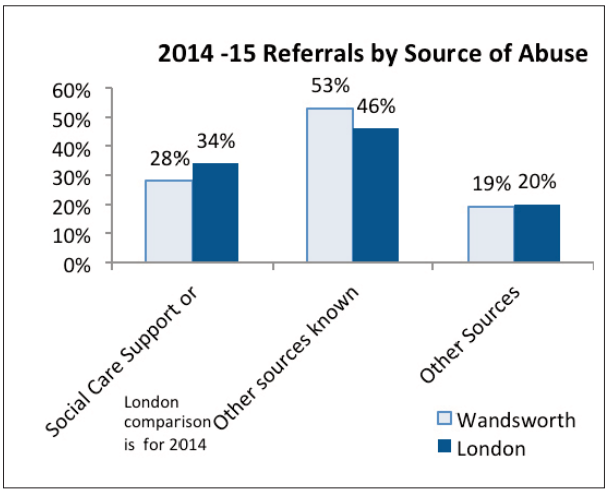
Table 3



The comparison with the previous year's figures for Wandsworth shows that there has been a further decrease in referrals for Black/Black British people, from 20% in the previous year, and the rate is now in line with the London average.

To put this in context, the population of Black people in Wandsworth has remained stable at 20% of all residents; and the proportion of Black people who are service users has reduced by 2.7% from the previous year.

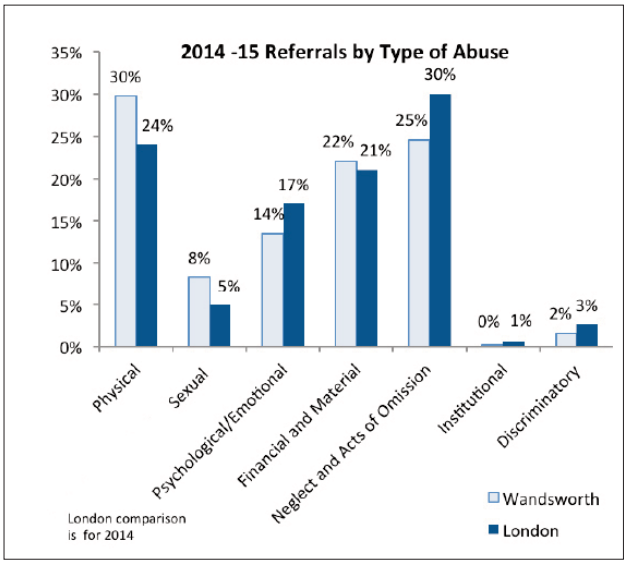
Table 4



There is a continued trend from the previous year of a slightly lower proportion of alleged abuse by staff from within services supporting people than in London generally. There is no reporting category for types of service provision, but it is known that approximately 6% of completed referrals related to domiciliary care staff, and this may in part explain the lower figure.

Risk to alleged victims in Wandsworth from unknown/stranger source is broadly similar to London.

Table 5

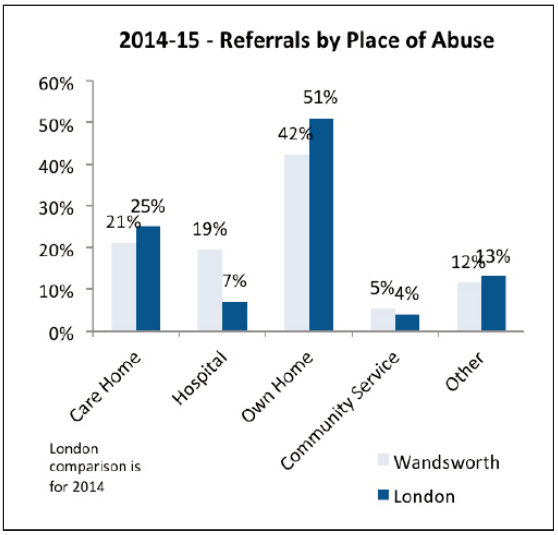


As was the case in the previous year, with the exception of physical abuse and neglect, Wandsworth is broadly in line with the London average.

In the previous year there had been an increase in referrals relating to neglect (16% to 23%), and this has slightly increased again in the reporting year (25%), but remains below the London average. The commensurate decrease in financial abuse in the previous year (23% to 16%) has been reversed (22%).

There are no figures for gender as completed referrals are not reported in this way.

Table 6



The incidence of abuse in the person's own home in Wandsworth has increased this year (37% to 42%), but remains low in comparison to the London average.

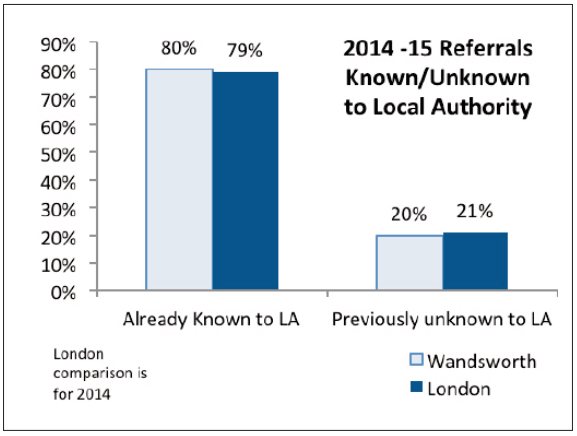
The low figure may in part reflect the low level of referrals from domiciliary care sources.

The difference will also be in part due to the higher rate of hospital referrals in Wandsworth than in London in general, due to the aforementioned siting of a mental health hospital in the borough, with 54% of hospital settings in this table relating to mental health settings. Also, the reduced figure for hospital settings in the borough this year (24% to 19%) may be explained by the reduced proportion of referrals of people in mental health hospital settings.

The figure for referrals in care homes has risen slightly this year (19% to 21%) and remains below the London average.

Table 7

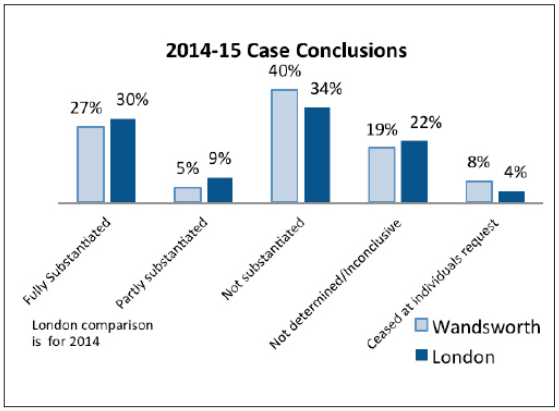
There is a continued trend from the previous year to an increased proportion of referrals in which the adult at risk is already known to Wandsworth 69% to 80%), and this is broadly in line with the London average.



There has been a reduction in repeat safeguarding referrals (relating to the same alleged victim) in Wandsworth this year (11% to 8%). Nationally repeat referrals have not been measured for the past two years, and the London average had been higher than in Wandsworth in the last year this was reported.

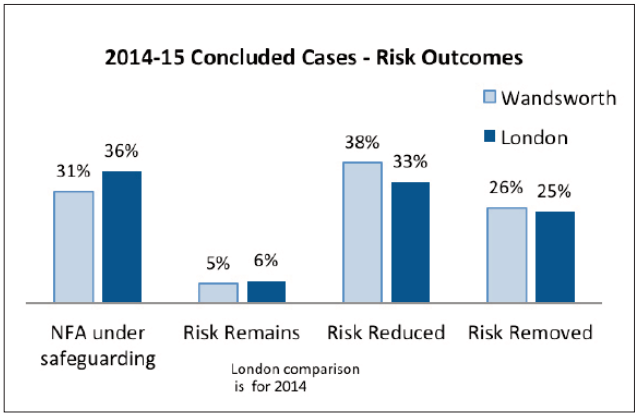
Table 8

There has been a decrease in the proportion of substantiated outcomes in Wandsworth this year (34% to 27%), falling slightly below the London average (32% to 30%); and an increase in the proportion of not substantiated outcomes this year (34% to 40%) against the London average (36% to 34%).



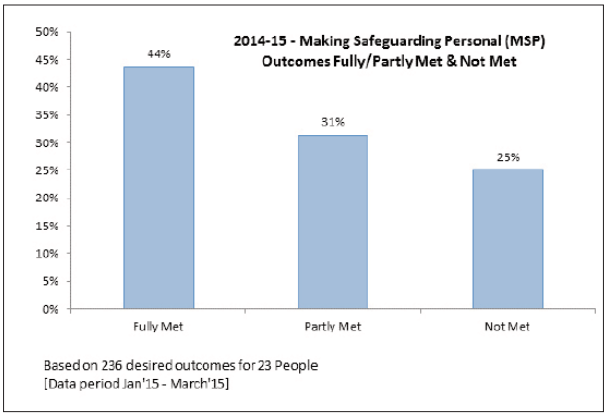
3 Safeguarding in numbers

Table 9



There has been a significant reduction in the number of cases requiring no action under safeguarding this year (49% to 31%). This corresponds with an increasing number of cases in which the risk has been removed (13% to 26%), which is in line with the London average.

Table 10



Reporting on Making Safeguarding Personal is a new reporting field in Wandsworth, introduced in the last quarter of the reporting year, and is not reported on nationally. The figures represent a small number of service users (23) and a much more representative figure will be reported in the next year.

The figures reflect that a high percentage of outcomes desired by the adult at risk were met or partly met this year (75%).

4 What the Partners did in 2014/15

Wandsworth Council Education & Social Services Department

This has been a year of significant change. Wandsworth Department of Education and Social Services (DESS) was formed in April 2014, combining Adult Social Care and Children's Services into one department. In tandem with this arrangement, the Safeguarding Adults Team became a part of the DESS operational service, leading to a closer working relationship, and is more closely aligned to the safeguarding children's service.

A comprehensive commissioned audit of safeguarding adults practice in March 2014 found that 81% of safeguarding adults cases were good or adequate and no situations were left unsafe. It concluded that safeguarding adults enquiries were conducted in a safe and sensitive manner. It also concluded that the eligibility threshold for safeguarding was not applied with sufficient rigour, leading to safeguarding enquiries at times when alternative responses would have been more appropriate. This led to an increased emphasis on proportionate referral decisions, with updated local procedures and guidance, alongside training and staff briefings. This has led to a reduction in referrals progressed as safeguarding and the deployment of alternative responses, such as complaints, when not progressed. An internal audit programme has evidenced safe and proportionate decisions and this practice and checking will be maintained. This has been further enhanced by clearer recording and reporting systems, with evidence of management oversight in decision making.

A comprehensive commissioned external audit of general social work practice in April 2015, which included an element of safeguarding adults, found that 94% of social work interventions were excellent, good or adequate, and no situations were left unsafe.

CASE STUDY

OP has a learning disability and was a victim of violence in an altercation with a peer. A safe-guarding adults enquiry led to physical abuse being substantiated and to a protection plan, which PO was core to developing, and created a safer environment. Afterwards, OP was interviewed about his experience of safeguarding and said that the Social Worker explained the process to him, he was able to take part in meetings, and he did not disagree with any decisions. OP also commented that the Social worker remains in contact with him and he is discussing rehousing. He concluded that;

"I feel very good and I am getting on with my life".

A further comprehensive external audit of safeguarding adults practice was completed in June 2015 (reported in time for inclusion in this report). This audit found that 95% of safeguarding adults enquiries were good (71%) or adequate, and no situations were left unsafe. It concluded that overall safeguarding adults practice is safe, proportionate, with management oversight, containing holistic and robust risk assessment, is personalised and concerned with wellbeing, and demonstrates an understanding of mental capacity and deprivation of liberty safeguards. The auditor also completed interviews with 3 adults at risk, and representatives, about the experience of safeguarding and whether the enquiry was responsive to desired outcomes. All the service users interviewed expressed overall satisfaction with the process and reported that they felt supported and informed, consulted on their desired outcomes, and that the appropriate people were involved. The audit report recommended that the development of best practice can be enhanced by an increase in multi-agency training opportunities and reflective practice discussions at team level.

The Care Act 2014 places an expectation on local authorities and SABs to ensure that safeguarding adults enquiries are personalised, with adults at risk listened to and fully involved. Making Safeguarding Personal has been a key priority during the reporting year, with the introduction of improved staff guidance; the provision of staff briefing sessions; and the implementation of an improved recording and reporting system from the final quarter. As outlined in the performance section of this report, 75% of adults at risk felt that their desired outcomes had been fully or partly met.

CASE STUDY

AC is a young woman who experienced' honour violence', in the form of physical and psychological abuse, from family members over a number of years. A Social Worker was assigned and developed a trusting relationship and a protection plan with AC, joint with the Police. As a result of safeguarding action, AC was supported in moving to a safe environment where she was able to build skills in independent living, thereby also improving her well-being. Afterwards, AC told the Social Worker that "they don't hurt me any more - you saved my life - thank you a million times for the rest of my life".

4 What the Partners did in 2014/15

The Care Act 2014 also places an expectation on local authorities and SABs to develop risk management processes in order to prevent abuse, and also to respond to self-neglect as a safeguarding concern. In response, and also as an action arising from an SAB Safeguarding Adults Review (outlined in this report), the local authority has led on the implementation of an improved Vulnerable Adults Risk Management Meeting (VARMM) procedure, providing a multi-agency team around the adult to mitigate risk; with an additional layer of response through a Community Multi-Agency Risk Assessment Panel (CMARAP). The success of these initiatives will be evaluated and reported in the annual report next year.

The Safeguarding Adults Team has continued to be effective in providing consultation within DESS and to external agencies; chairing and minuting safeguarding adults and VARMM meetings, and coordinating enquiries relating to adults at risk when the funding/placing authority is not Wandsworth; alongside strategic support to the SAB, contribution to addressing provider concerns, quality assurance and performance monitoring, provision of staff briefings and training, and distribution of publicity.

CASE STUDY

GT is a 70 year old man with schizophrenia who lives with his wife, WT, in their own home. They have a complex relationship which can at times be volatile. WT went to live with friends following an argument with WT and this resulted in temporary respite being arranged.

A DOLS application was requested as GT stated that he wished to go home and WT also wished to have him home. The BIA visited and stated that the placement was not in his best interest and that he should return home with an appropriate support. GT was then discharged home

The local authority has supervisory responsibility for Deprivation of Liberty Safeguards (DoLS); which involves assessing that adults lacking mental capacity in care and nursing homes and hospitals, who are under continuous supervision and are not free to leave, are not subject to unreasonable restrictions. This responsibility is invested in the Safeguarding Adults Team, which coordinates receipt of referrals, commissions assessments, and completes authorisations. Due to the Cheshire West judgement in March 2014 the number of referrals nationally has increased significantly; in Wandsworth from 37 in 2013-14 to approximately 500 in 2014-15.

CASE STUDY

AB is a woman of 87 and has lived in Honey Tree Lodge, a home outside of Wandsworth' for a number of years. Following the clarified definition of what constitutes a Deprivation of Liberty following Cheshire West, a standard authorisation request was made. AB met the qualifying requirements for an authorisation, however, during the assessment the BIA witnessed an incident which triggered a safeguarding alert to the host borough safeguarding team. This resulted in an investigation and appropriate action taken.

Almost all social workers and practitioners in Wandsworth have received appropriate safeguarding training within the past 3 years and a new advanced series of training modules has commenced, towards further enhanced safeguarding adults practice.

Concerns were raised about the standard of care provided in a nursing home in the borough. These included issues about the delivery of care and treatment, personalised care plans, dignity, activities, communication with relatives and professionals, staffing levels and training. A provider concerns response was put in place by Health and Social Services, with the nursing home providing evidence of actions to improve care. This has included considerable outside support to the home and evidence of increased staffing, person-centred care plans developed and reviewed monthly, daily checks on dignified care, relevant training arranged, improved communication, activities champions provided, and improved management oversight. The provider concerns response will continue so that there is consistent evidence of good quality care.

CASE STUDY

Concern was raised that QR, who has a learning disability and can be anxious, may have been a victim of theft and is vulnerable to peers who manipulate him. Ongoing Social Work support is provided to enable QR to manage risk to his safety. In an interview, QR's family said that they and QR were fully involved in the safeguarding process, that QR is able to walk away and ring the Police if threatened, and the Social Worker continues to support him.

Probation Providers

The primary challenge has been managing safeguarding practice within the context of the national divide of the Probation Service into the National Probation Service and the Community Rehabilitation Company from April 1st 2014. Both the NPS and CRC are represented on the Wandsworth Safeguarding Adults Board, to ensure that the organisations display practice and accountability in line with the board. Local Managers also hold bi-monthly meetings to ensure that any interface issues are addressed.

The implementation of the 2015 Offender Rehabilitation Act (ORA) now requires London CRC to provide Licence and Post Sentence Supervision to all offenders sentenced to custodial sentences for less than 12 months. This will result in new group of service users under CRC supervision; with the cohort of people incorporating women, 18-25 year olds, adult males, males 50 plus, and those with mental health and intellectual disabilities. To ensure that all staff are confident in preventing and detecting safeguarding issues, training events will be held throughout 2015. Local briefings on the aforementioned CRC Guidance are also being held.

The guidance stipulates that all safeguarding concerns should be discussed with line management in order to make a decision whether to contact the local authority. A home visit will also be undertaken in order to assess the risk further. At risk individuals will also be taken into account when addresses are being assessed for suitability of residence for service users.

Service users who are a risk to others or at risk from others will be flagged on our case recording system. We also performance monitor the data quality of victims of domestic abuse.

Communication relating to safeguarding is relayed through the following channels-

* Each borough has a Safeguarding Adults Lead Officer. The Wandsworth lead has informed all CRC staff of the referral route and process into the Local Authority.
* The London CRC intranet contains a safeguarding adults page which includes all up to date policy and guidance information. This is updated by the London CRC Safeguarding Adults Lead Assistant Chief Officer.

The London CRC has issued a Safeguarding Adults Guidance to all staff, which is consistent with the Care Act 2014. Under the Act, providers of probation services have a duty to co-operate with local authorities in respect of social care. The London CRC Guidance has also been developed in line with recommendations contained within Protecting Adults at Risk: London multi-agency policy and procedures to safeguard adults from abuse, which was published in January 2011 by the Social Care Institute for Excellence (SCIE).

The Police

Since January 2015 the police teams involved in 'safeguarding' have been realigned under the management of one Detective Chief Inspector. This is a first for London and is seen as a pilot for effective safeguarding work. This structure is in response to the need for a more holistic approach towards safeguarding both adults and children and enables improved communication and governance between teams. The police teams are split into three portfolios, each under an Inspector.

One Inspector manages the Safeguarding, Partnership, and Youth Team, which is subdivided into three parts. The Youth team incorporates the Youth Offending Team, Volunteer Police Cadets and the Safer Schools officers assigned to the secondary schools in Wandsworth. The Partnership Team looks after Licensing and other partnership work, such as the Drug Intervention programme, with the local authority. Thirdly are the new Missing Persons and Mental Health Liaison Unit. The latter unit aims to ensure a more consistent approach to missing people. We hope to reduce the incidence of missing person reports through more home visits and multi-agency interventions aimed at repeat missing persons.

A Detective Inspector is responsible for the Community Safety Unit, dealing with domestic abuse and hate crime, the Multi Agency Safeguarding Hub and the Wandsworth Family Recovery Project.

Led by a second Detective Inspector the remit of the Gangs Taskforce has been expanded to include proactive safeguarding investigations and is now known as the Gangs & Safeguarding Task Force (GSTF). This Inspector is also responsible for the Public Protection Team (managing dangerous offenders and Registered Sex Offenders) and Integrated Offender Management.

All three portfolios now come together formally once a week for a Safeguarding conference call, to share information, identify vulnerable adults and discuss issues of concern. There is an agreed set of actions to support these people or manage the locations, and a lead unit assigned. This has already enabled knowledge to be shared more effectively and has led to interventions to protect both adults and children.

Wandsworth Police recently held a first monthly meeting involving other Wandsworth agencies, such as Social Services, to ensure that people who need our help are provided with the most effective and targeted support possible. This has enabled us to introduce safeguarding matters into the borough monthly tasking process.

4 What the Partners did in 2014/15

Number of *Merlin adult coming to notice* reports by Police to Social Services of vulnerable adults:

The figures shown below show how awareness has been raised in terms of the reporting of vulnerable adults by police. This enables more effective intervention and prevention tactics to be considered and deployed where necessary.

01/04/2014 - 31/03/2015 = 1380

01/04/2013 - 31/03/2014 = 793

Disability hate crime has historically been under reported. To address this it formed part of the hate Crime Awareness week 2014. A disability hate crime roadshow was held within Southside to encourage increased reporting of crime.

Staff vacancy rates continue to be a challenge. To ensure an effective response, the numbers of officers within the CSU have been maintained above the baseline.

The sharing of information can be problematic, in terms of individual staff members having the confidence to share information. Staff are encouraged to share information through the weekly internal safeguarding conference call. Additionally, the process for reporting matters of suspected adult abuse to the police has been reviewed and improved. This is now embedded and has improved the police response through a single pathway into the CSU.

To further improve communication with partners, meeting attendance by police has been reviewed and streamlined to ensure that the right people attend the right meetings to provide an effective input.

CASE STUDY

SK is an Indian man with a learning disability who lives with his family. He was subject, with his mother, to an aggravated burglary at their home. A Police-led safeguarding adults enquiry ensued and the suspects could not be identified. However, a robust protection plan was put in place which improved their safety; including provision of a wide range of home security devices and advice on personal safety. SK has gradually overcome his fear of living at home.

Policing of mental health continues to be challenging. Assessments of patients under section 136 and the lack of immediately available beds causes increased demand on police, with officers often spending hours looking after patients. Initial attempts have been made to improve this situation. A pilot scheme has taken place to improve the immediate response to people with mental health conditions and to identify alternatives to a section 136 referral. This involved a direct line of contact to appropriately trained staff, with access to medical records, enabling a more effective response and assessment. The impact of this trial is currently being assessed.

There have been a small number of high risk absconders during the year. These individual cases create a high impact on local policing. Investigators are moved from crime investigations to expedite the recovery of the missing individual, to minimise the potential of risk to the individual and the public. As well as the human resource implications, the financial cost on occasions has been large. Wandsworth Police are currently working with partner agencies to reduce the number of absconders and improve the initial response.

CASE STUDY

A safeguarding adults enquiry and protection plan were put in place when concern was raised about possible theft from MN, an older woman. A relative provided advocacy support and a random follow-up interview was held. MN said that he was kept up to date on progress and that his relative was able to contribute. Social Work support was provided and a Police enquiry held. Although there was no evidence of financial abuse, the advocate commented that his relative was safer as a result of safeguarding, due to improved management of finances.

St George's Healthcare NHS Trust

St George's Healthcare NHS Trust is committed to ensuring that all patients receive safe, effective and dignified care. We have a duty under Care Quality Commission (CQC) regulations to ensure that those adults most at risk are "protected from abuse and that staff should respect their human rights". In 2014/15 the lead nurse for adult safeguarding dealt with 855 contacts across the whole of the organisation and across different boroughs. These contacts or referrals were screened for evidence of neglect and abuse and a proportion of these (approximately 30%) were referred on to local authorities as safeguarding alerts. Where possible, the lead nurse identifies the patient's wishes in regard to their expected outcome and ensures that this is shared with the local authority.

The impact of the "Cheshire West" Deprivation of Liberty Safeguards (DoLS) judgement has had a significant impact on how the trust responds to deprivations of liberty and the resources necessary to be fully compliant with the new "acid test".

The scope of adult safeguarding continues to broaden and despite the Pan-London procedures being well utilised, there remain the inconsistencies in practice and application between different boroughs and agencies.

Advice is often sought on complex matters, which are often not of a safeguarding nature. Frequently these cases have a mixed picture involving multiple agencies, complex family dynamics, and questions regarding mental capacity/mental health, identification of a decision maker, difficult ethical/professional judgements, safety and/or safeguarding concerns, discharge destination, funding and roles and responsibilities. It is often a case of unpicking each situation as, although some have similar themes, each case has its own unique features. Once unpicked, any safeguarding matters relating to neglect or abuse can then be addressed.

It is often challenging to identify the roles and responsibilities of all agencies and individuals involved in complex safeguarding cases. In these cases it is important to utilise a multi-disciplinary approach and ensure a close and positive relationship is established with the patient/client. For instance, the community teams work closely with their social work and health colleagues to identify those at high risk of possible abuse, and work together to put strategies in place to help mitigate risk.

South West London and St George's Mental Health Trust

During 2014/15 the Trust reported internally 401 safeguarding concerns related to incidents that occurred in the borough: 70 of these incidents were referred to, and managed, externally by the borough Safeguarding Adults Team; 103 incidents were managed locally at ward/team level; and the remaining 228 incidents managed by Trust based Safeguarding Adults Managers.

CASE STUDY

BE is a middle-aged woman with a long history of mental health issues. BE had difficulties in maintaining her environment and looking after herself. Even though her tenancy became at risk she was adamant she did not require any support. BE also had disengaged with primary health services. As a result of a safeguarding referral, housing, mental health, GP and social services worked together to come up with a plan to engage with BE. As a result of this plan, essential repairs to the property were achieved, securing her tenancy. BE received health checks for the first time in many years and is currently engaged in an assessment for further services.

The Trust Service Director and both the local Safeguarding Adults Leads, and the Trust wide Adult Safeguarding Lead, have strong working relationships with local authority Safeguarding Adults Team. The key role of the Safeguarding Adults Manager (SAM) has been supported through the Directorate Safeguarding Lead and Trustwide Lead.

The Safeguarding Adults Quality Account project in 2013/14 raised the profile of adult safeguarding further across the Trust and helped to embed effective, consistent governance systems and structures into frontline and management practice across the Trust. The Trust has built on this foundation throughout 2014/15. Most recently this has included a focus on the implementation of the 'Making Safeguarding Personal' guidance – to ensure people receiving safeguarding services can stay in control as much as possible and have an outcome they want. The Trust has worked closely with its local authority partners and is prepared for the changes in practice required under the Care Act 2014 and its associated guidance. This included comprehensive review and updating of policy documents and engaging service users in service developments.

4 What the Partners did in 2014/15

The integration of the reporting systems for safeguarding, complaints and incidents has provided staff and managers with greater oversight of trends, and patterns of allegations and service issues. Joint working between the Director of Social Work and Head of Quality and Governance has been essential to the successful completion of these changes.

New guidance on the reporting of medication errors was developed with Safeguarding leads, Nurse Managers, and Pharmacy Leads. This provides detailed guidance on the local authority threshold for reporting such incidents.

The acuity of the Trust's service users has increased and this may have the effect of increasing levels of vulnerability to exploitation or abuse or neglect. This, combined with national bed management issues, has been the greatest challenge this year.

The Directorate and Corporate scrutiny of safeguarding activities has generated a better understanding of the scope and impact of abuse and neglect. This has informed service developments and the key challenge is to embed the lessons learned from these incidents, and thereby minimise the risk of recurrence.

The Trust Executive and Board need to work more closely with the Safeguarding Adults Board to learn from reviews and reports into serious, multi-agency safeguarding incidents; and to align the Trust's objectives with local authority priority issues and concerns.

The Quality Strategy sets out how the Trust has identified and will implement personalised quality improvements and how it will sustain consistent compliance with all regulatory and statutory requirements.

Compliance with Trust level 1 'basic awareness' has improved consistently over the year and has ranged from 80 to 95% compliance. The Prevent Lead has scheduled monthly 'Workshops to Raise Awareness of Prevent' across all sites.

The Trust has been working to fulfil the recommendations from nationally reported hospital abuse scandals involving celebrities, particularly Kate Lampard's Department of Health 'Lessons Learned' report. These actions are aimed at preventing such incidents from occurring again. Policy, practice and performance have all been subject to review and revision to ensure that the highest standards are maintained

Wandsworth Clinical Commissioning Group (WCCG)

The safeguarding lead was successful in bidding for CCG money to employ a Project Manager to review its mental health and learning disability providers' safeguarding polices. WCCG is now assured that all our mental health and learning disability providers have a robust safeguarding policy in place with clear lines of reporting adult abuse.

Wandsworth CCG's Quality Team is mindful that it is accountable for ensuring that its safeguarding adults structures and processes are in place, and that those agencies from which it commissions services meet the required safeguarding standards.

WCCG staff have been encouraged to attend the Local Authority-led Care Act 2014 awareness sessions in the first quarter of this year. The CCG is keen to work with the Wandsworth health economy partners to become Care Act compliant and to embed the Care Act legislation in practice during the coming year.

WCCG has been successful in a bid for NHSE funds to commission Mental Capacity Act awareness training across Wandsworth. This is currently underway and receiving excellent reviews.

Alongside this, the CCG is responsible for actively engaging with the work of the Wandsworth Safeguarding Adults Board, represented by the Deputy Director of Quality and Lead Nurse (appointed December 2014), and also the Safeguarding Adults at Risk Lead Nurse.

Wandsworth CCG (WCCG) has continued to forge excellent working relationships with its health economy partners in 2014/15. It maintains close working relationships with the Continuing Health Care team, Local Authority Commissioners and the CQC in relation to safe care in care homes across Wandsworth. Early detection of safeguarding concerns is shared between agencies through effective partnership working, to improve standards and quality of care through robust, proactive responses and multi-agency working.

WCCG has continued to support the wider Wandsworth team by taking an active part in SAB sub-groups that feed into the work of the SAB. It has been a key contributor to Safeguarding Adults Reviews, Domestic Homicide Reviews and Provider Concerns meetings, providing clinical advice and input where required.

Wandsworth Council Housing Department

The Housing Service, part of the Housing and Community Services (HCS) Department, provided refresher safeguarding children and adults training to 204 front-line officers during the last part of 2013/14 and the first part of 2014/15. The training covered safeguarding in general as well as focusing more specifically on housing processes and procedures for when and how to make appropriate safeguarding alerts. The training also focused on the think family approach. The percentage of staff who had attended training within the last year rose to 71 per cent.

In May 2014 private registered providers (PRPs) were invited to nominate a representative to sit on the Safeguarding Adults Partnership Board. This would allow the representative to provide views about safeguarding issues being experienced by PRPs and feedback any appropriate information arising from the meetings to other social housing providers with stock in the borough. A representative was selected in September 2014.

In October 2014 an update on safeguarding children and adults was provided to the Registered Social Landlords (RSL) Chief Executive meeting. This included information on available safeguarding training and the intention to train a pool of trainers within partner's agencies to ensure quality and consistency of approach. This is a standard item on these agendas and regular mailings are also undertaken to alert PRPs to changes in practice, approach, developments, requirements and training opportunities.

A Policy Officer from the Housing Service attended the 'Train the Trainer' basic awareness safeguarding training in November 2014 and February 2015. The delegates on the course are committed to undertake at least two training courses for their agency each year.

In February 2015 all floors and the main reception areas of Garratt Lane were checked to ensure the most up to date safeguarding posters were being displayed. The Housing Service is in the process of relocating to two different sites and the same checks are being made as the moves are completed.

A safeguarding adults and children article was published in the March 2015 edition of Homelife which is delivered to 33,000 Wandsworth households living in council tenanted or leasehold accommodation.

An updated information pack was provided to the Accommodation Placement and Support Manager in October 2014 to distribute to B&Bs providing a service on behalf of the Housing Service reminding them of safeguarding reporting and responsibilities.

A gap analysis was conducted on the Care Act 2014 and included any actions which needed to be implemented to comply with the legislation with regards to safeguarding adults. Following the analysis a joint meeting was arranged with DESS to discuss the implications of the Act which concluded that staff will require training to ensure they are aware of new responsibilities surrounding Safeguarding Adults.

During 2014/15 22 safeguarding adult's alerts were made by staff within the Housing Service. This is consistent with previous years, being 18 in 2013/14 and 27 in 2012/13 and suggests that concerns are being reported where appropriate. The collective activities set out above have ensured that there is a very high level of awareness amongst staff as to their safeguarding responsibilities as evidenced from feedback on the training. A programme of training and publicity is now firmly established and will continue to be implemented in 2015/16.

The Housing Services' main challenge in the 2014/15 year has been in trying to improve outcomes for vulnerable tenants who, for example, have mental health issues and do not engage. There has been some difficulty in involving a wider range of agencies where tenants are at risk of eviction and ensuring staff understand thresholds for engagement of services. This has been addressed by improving multi-agency working through greater communication amongst partner agencies and clarification of responsibilities. This will also be further strengthened through the revised Joint Working Protocols and a new eviction procedure that will strengthen and clarify arrangements required to check the details of households facing eviction.

The implementation and preparation of the Care Act in April 2015 has presented a positive challenge to the Housing Service by the introduction of self-neglect as a safeguarding category. Self-neglect has a particular relevance to the Housing Service where there are issues such as hoarding to an extent which jeopardises a person's tenancy, by breaching their tenancy conditions. This would have previously been handled as a non-safeguarding referral and housing staff would have known this to be firmly established in procedural requirements, the Housing Service has addressed this by developing new procedures that conform to cross-departmental processes agreed by the SAPB.

The Housing Service has also, in line with other London boroughs, experienced rising homelessness demand particularly from the private rented sector (PRS). This has led to an increased use of temporary accommodation further away from the borough where an adult at risk of abuse and neglect may not be identified as easily. To address this, the Council has developed a policy of acquiring, where appropriate, high quality temporary

accommodation as close to the borough as possible managed by the Housing Service which will help to identify safeguarding concerns. Additionally temporary accommodation is inspected by housing officers who can highlight and raise any safeguarding issues.

The Housing Tenancy Support Service (TSS) provides intensive advice and support to vulnerable residents who may be at risk of, or experiencing abuse and neglect to assist them to successfully manage their tenancy and provides sheltered warden services to nearly 1,000 elderly households. The TSS worked with 171 tenants during 2014/15 providing a range of personalised support to tenants with differing vulnerabilities, although rent arrears are a factor for the majority. Tenancy Support officers (TSOs) continue to enhance the service provided as well as signposting service users to specialised services.

The Supported Housing Service also manages 24 sheltered housing schemes which provide independence to older residents with the reassurance of an alarm service and Sheltered Housing Officer (SHO) onsite for assistance and support. SHOs work with all residents to develop and put in place a support plan for them and also identify and monitor safeguarding concerns amongst the schemes tenants. In 2014/15 the supported housing service has introduced a hoarding database for tenants in sheltered housing to coordinate effective responses to help vulnerable adults who self-neglect. These two services have continued to be provided with additional training in respect to safeguarding responsibilities, ensuring that they have the skills to address any safeguarding issues that may arise.

The Housing Service has maintained effective joint-working relationships with colleagues, particularly in the Department for Education and Social Services (DESS). The Policy and Performance Officer with responsibility for safeguarding adults continues to meet with the Safeguarding Adults Policy & Development Manager on a regular basis to review the safeguarding referrals made by housing staff and monitor the action taken by DESS. This includes whether a response went to the referrer within the agreed timescale, and review whether the safeguarding alert flag should be removed from the Housing Service's system. These discussions have indicated how important it is for Housing Service staff to receive timely feedback on referrals made. This is needed both for the purposes of Housing staff being kept informed of specific cases in order that they can be involved in decision making and take necessary action as appropriate, and crucially in maintaining a full commitment within Housing Services to continue to make appropriate safeguarding referrals, understand when these should be made and to see clearly what actions are taken as a result.

5 What the Board Did in 2014/15: A Snapshot of Key Progress

Safeguarding Adults Board

In preparation for implementation of the Care Act 2014, the membership of the Board was reviewed to ensure cross-community representation at a decision-making level. This led to new partners joining, including Healthwatch and a Housing Association representative. It also led to higher level representation, including the Wandsworth Police Borough Commander.

The Board also agreed in principle a localised version of the pan-London Information Sharing Protocol. This is an agreement by partner agencies to share information needed to meet our statutory obligation to safeguard adults at risk from abuse.

The Board reviewed and updated the Safeguarding Adults Review procedure in line with the Care Act 2014 requirements.

Quality Assurance and Performance Monitoring Sub-Group

As outlined in the Safeguarding – In Numbers section of this report, there has been an improved level of assurance that safeguarding arrangements are effective, including improved information on outcomes.

As a thread through this report, there is clear information on trends that informs actions moving forward to further enhance safeguarding.

5 What the Board Did in 2014/15: A Snapshot of Key Progress

Policy & Procedures Sub-group

In preparation for the implementation of the Care Act 2014, and updated pan-London policy and procedures, improved procedures and guidance were put in place to ensure that safeguarding enquiries led to safe, proportionate and personalised outcomes. This included improved partnership working arrangements between Social Services, Health, the Police and other agencies.

There has been an improved emphasis on risk management to prevent abuse and in response to self-neglect, which is now considered to be a form of abuse. This has led to Vulnerable Adults Risk Management Meetings in which the multi-agency team around an adult at risk work together to minimise or reduce the risk of harm. A new Community Multi-Agency Risk Management Panel made up of senior managers in agencies has also been set up as an extra layer of intervention when risk remains.

There has been a substantial rise in the number of Deprivation of Liberty Safeguards assessments, which is a statutory requirement on local authorities to ensure that adults at risk who lack mental capacity do not have unreasonable restrictions placed on their freedom. This has led to increased protection and wellbeing for many adults.

An updated Provider Concerns procedure has been developed alongside a multi-agency Quality Control Panel; leading to improved information sharing and improved quality standards by service providers.

These initiatives have led to further improved safeguarding adults practice and prevention of abuse and neglect, as evidenced in the quality assurance and performance monitoring section of this report.

Workforce Training & Community Awareness Sub-Group

The Workforce Training Plan was further improved with new and improved training courses, including advanced training to equip practitioners and managers to carry out effective safeguarding enquiries.

Staff briefing sessions were held in Social Services to ensure staff familiarisation with the priorities of safe, proportionate and personalised enquiries.

Wandsworth has an annual commitment to a local joint safeguarding adults and children's safeguarding week, with information stands set up in supermarkets across the borough during June.

Safeguarding Adults and Children's Sub-Committee

This sub-committee was set up to ensure effective joint reporting and working by practitioners across generations, leading to an improved Think Family approach. This has included joint training of staff and audits of cases to improve practice.

5 What the Board Did in 2014/15: A Snapshot of Key Progress

Safeguarding Adults Review

A Safeguarding Adults Review was commissioned by the Safeguarding Adults Board during 2014-15 into the death of AB (changed initials). There is a concurrent Coroner's investigation and the executive summary of the review report will be published at the close of this process.

AB was a 47 year old woman at the time of her death in March 2014, She was considered to have a range of complex mental health and behavioural concerns. AB had been detained in a psychiatric hospital on a number of occasions. The care services involved found providing care consistently problematic due to a difficulty to engage.

AB was found dead in her home by Police and a range of medical causes were identified.

The Safeguarding Adults Review reported in December 2014 and concluded that the serious health problems and death could have been predicted through an improved multi-agency risk strategy, but that it is not possible to say that her death was preventable.

The learning points and recommendations were followed up in a multi- agency action plan. Most significantly this has directly led to the development of the Vulnerable Adult and Risk Management Meeting (VARMM) and Community Multi-Agency Risk Assessment Panel (CMARAP) initiatives which are outlined in this report.

6 Challenges and Opportunities in 2015/16

There are a number of challenges and opportunities in 2015-16, all of which are covered in this report. These include:

- Implementation of the Care Act 2014, with the focus on information sharing by partner agencies to prevent abuse; and to safe, proportionate and personalised safeguarding enquiry outcomes.
- Embedding the learning from the Safeguarding Adults Review, including the improved multi-agency risk management initiatives to prevent and respond to abuse and neglect.
- Prioritisation of effective information sharing and responses to provider concerns to prevent and respond to abuse and neglect.
- Further improve management of the substantial increase in Deprivation of Liberty Safeguards assessments.
- Develop a planned shared workforce between Wandsworth and Richmond local authorities, including the development of shared safeguarding adults and DoLS services.

7 What The Partners Will Do in 2015/16: A Snapshot

Wandsworth DESS ▶

- Safe, proportionate and personalised enquiries enhanced through developing a shared service with Richmond; localising revised pan-London policy and procedures; embedding personalised practice; improving joint working arrangements
- Effective risk management enhanced through VARMM and CMARAP
- Effective provider concerns responses and promotion of dignity enhanced through the Quality Control Panel
- Effective deprivation of liberty safeguards enhanced through a service review
- Improved quality assurance and performance monitoring, with an emphasis on auditing practice
- Workforce training and community awareness, including training to care home residents and staff and a Wandsworth Safeguarding Conference

St George's NHS Trust ▶

- An update of the safeguarding procedures in line with the expected revised Pan London Procedures
- Revision of training modules in line with the Care Act and Skills for Health standards
- Revision of MCA and Deprivation of Liberty procedures
- Completion of NHS England assurance framework
- With the formation of the Wandsworth Police safeguarding portfolio of teams internal strategic objectives have been set as follows; Make Wandsworth safer:
- Through early, proactive and preventative interventions.
- By conducting thorough and effective victim based investigations to achieve a positive outcome for the victim.
- Through working with partners to identify and manage risk to deliver effective outcomes.

London CRC ▶

- The London CRC are working closely with MTCnovo to transform the way in which probation services are delivered and together develop new ways of working. The proposed operating model will introduce 'cohorts' – women, 18-25 year olds, working age males, older males and those with a chronic illness, mental illness or intellectual disabilities – whereby offenders are worked with based on their primary presenting need. This will allow front line staff to be better able to identify needs and issues and access the services to which they are entitled to make significant improvements to their quality of life which therefore reduces their chances of reintegration into society and increases the risk of reoffending..
- London CRC's priorities in 2015/16 are to ensure through an ongoing training programme, monitoring and evaluation that all front-line staff are knowledgeable in relation the Care Act 2014 and understand their responsibilities when working directly with service users who are 'adults at risk' to be aware of issues of abuse, neglect or exploitation, that they have a duty to act in a timely manner on any concern or suspicion and to ensure that the situation is assessed and investigated.
- London CRC will use and develop our existing case recording systems to demonstrate that we are making improvements in all identified safeguarding adult cases and that there is evidence that the assessed level of need is being met.

Wandsworth Police ▶

- Wandsworth Police have introduced a governance process, which includes a weekly risk based conference call, a monthly meeting with partners to identify recurring themes and to decide on how resources should be tasked against safeguarding priorities.

7 What The Partners Will Do in 2015/16: A Snapshot

Wandsworth Council Housing Deptartment ▶

- The main Housing Service priority for 2015/16 is to continue effective working relationships to ensure a comprehensive approach is taken to identifying and responding to safeguarding issues, this will be implemented through the review of the Joint Working Protocol with partner agencies and will include implications of the Care Act.
- The Housing Service will continue to ensure that staff have a good knowledge of adult safeguarding and the changes introduced in the Care Act through a combination of promoting and conducting relevant training, news items in staff publications and attending team meetings. Additionally, all safeguarding procedures will be reviewed and updated to reflect the changes in the Care Act, including the VARMM and CMARAP processes in cases of self-neglect and a new joint eviction procedure for the Rent Collection Service and Housing Services.
- The Housing Service will continue to promote community awareness of adult safeguarding by producing a joint children and adult safeguarding letter to contractors/service providers/PRPs, and as required working with the leasehold and procurement manager to ensure these are sent out to all new contractors and with the Accommodation Placement Manager to ensure they are sent to temporary accommodation providers.
- Following on from the refresher training delivered in 2013/14 and 2014/15, the Housing Service is in the process of producing an online refresher course that can be undertaken periodically by all staff in the Housing and Community Services Department. This will enable greater numbers of staff to be trained and reminded of their responsibilities. This will not replace introductory safeguarding training and all new staff or those who have not attended safeguarding training in the past will be encouraged to attend training provided by TPD.
- There will also be a continued focus on ensuring that housing service officers are aware of the work of and the referral process to the FRP particularly as its role expands and of any restructures taking place within DESS and the CMHT safeguarding adult's teams.

Mental Health NHS Trust ▶

- Mental Health Trust - The Care Act 2014 has widened the scope of safeguarding adults issues, while providing guidance on broader range of responses. This shift in culture is welcomed, and the Trust has initiated a service user and carer consultation group to raise awareness and co-create services.
- Operational Managers are responsible for ensuring service delivery is complying with standards and they are accountable to the Executive leadership, Service and Clinical Directors. The quality of the safeguarding intervention, the capture of service user feedback, and learning from audit and activity trends will be key indicators.
- The new Safeguarding Adults Review (SAR) process is monitored by the Adult Safeguarding Lead with the support of the Head of Quality and Governance and is now a standing item on the agenda of the monthly Safeguarding Adults Quality Group (SAQG).

8 What The Board Will Do in 2015/16: A Snapshot

Safeguarding Adults Board ▶

- Develop and achieve an updated annual Board Strategic Improvement Plan
- Improve and embed the local version of the pan-London information sharing protocol

Policy and Procedures Sub-Group ▶

- Reinforce the objective of safe, proportionate and personalised enquiries through implementing the pan-London policy and procedures with local arrangements; including eligibility thresholds, Making Safeguarding Personal, Think Family and partnership working.
- Further improved risk management arrangements to prevent abuse and respond to self-neglect; including oversight of high risk cases and embedding the VARMM and CMARAP initiatives.
- Further improved shared intelligence and responses to service provider concerns through the multi-agency Quality Control Panel, with an emphasis on working with providers to promote dignity, to prevent and respond to abuse and neglect.
- Review the Deprivation of Liberty Safeguards service to further improve effectiveness in managing the substantial increase in referrals and assessments.
- There will be a continued emphasis on working with the Mental Health Trust on assurance of safe practice on mental health inpatient wards.

Quality Assurance and Performance Monitoring Sub-Group ▶

- Further develop a multi-agency quality assurance and performance monitoring dashboard, providing assurance to the Board and partner agencies that abuse and neglect are being prevented and that enquiry outcomes are safe, proportionate and personalised. This will include an increased emphasis on desired outcomes and on a range of audit approaches.
- Performance monitoring will include a focus on risk thresholds, substantiated outcomes, making safeguarding personal, BAME referrals, domiciliary care, care and nursing homes, and mental health inpatient wards, which are areas highlighted in 2014-15 quality assurance and performance monitoring.

Workforce Training and Community Awareness Sub-Group ▶

- Further improved workforce training plan with new and improved courses. These will include advanced training on conducting safeguarding enquiries; achieving best evidence joint training with the Police; joint training to residents and staff in care homes on awareness of abuse and promotion of dignity; and continued briefings to safeguarding Adults Managers, Social Work Teams and partner agencies on enhanced practice, alongside the promotion of team champions. There will also be a focus on training in mental health inpatient wards and to domiciliary care agency staff.
- Further improved management and reporting on multi-agency attendance at relevant training for competency levels; alongside clearer evaluation of the effectiveness of training on influencing improved practice.
- Completion of a bi-annual Wandsworth Safeguarding Adults Conference in the Town Hall Civic Suite, with a wide range of participants from across the borough, on the theme of implementing the requirements of the Care Act 2014.
- Increased engagement with community groups to raise awareness and reporting of abuse, including BAME and faith communities.

9 Strategic Improvement Plan 2015-16

The Safeguarding Adults Board is committed to a vision that all adults at risk in Wandsworth are able to live free from abuse and with improved wellbeing.

No.	Objectives	Actions	Responsible Officer	Timeframe	RAG Rating	Progress
1	A Safeguarding Adults Board that works in partnership to oversee an effective safeguarding adults service in the borough.	Develop and achieve an updated annual Board Strategic Improvement Plan.	Nicky Pace	July 2015		Draft annual strategic improvement plan to SAB on 28/07/15.
		Produce an Annual Report reflecting the work of the Board over the previous year and the planned action to achieve objectives.	Clive Simmons	July 2015		Draft Annual Report to Board on 28/07/15.
		Improve and embed the local version of the pan-London information sharing protocol.	Nicky Pace	October 2015		Draft version agreed by SAB in principle on 28/04/15; due for revision.
		Review and update the Safeguarding Adults Review procedure in line with the Care Act 2014.	Nicky Pace	April 2015		Completed.
2	Safe, proportionate and personalised safeguarding adults enquiries in response to the suspected abuse and neglect of adults at risk.	Plan and develop Wandsworth DESS and Richmond SSD shared safeguarding adults and deprivation of liberty safeguards service.	Dawn Warwick/ Kerry Stevens/ Clive Simmons	April 2016		Initial scoping report on structure options completed.
		Implement the revised pan-London policy and procedures with local arrangements; including eligibility thresholds, Making Safeguarding Personal, Think Family and partnership working.	Clive Simmons/ David Parry	January 2016		Pan-London policy and procedures scheduled for implementation in January 2016; local procedures and guidance already updated and to be reviewed.
		There will be a continued emphasis on working with the Mental Health Trust on assurance of safe practice on mental health inpatient wards; including benchmarking other local authorities with a mental health hospital provision.	Jeremy Walsh/ David Parry	November 2015		Working arrangements with Trust as a service provider from November 2015 initiated.

No.	Objectives	Actions	Responsible Officer	Timeframe	RAG Rating	Progress
3	Effective risk management to prevent abuse and neglect and in response to self-neglect.	Further improved risk management arrangements to prevent abuse and respond to self-neglect; including oversight of high risk cases and embedding the VARMM and CMARAP initiatives.	Kerry Stevens/ David Parry	July 2015		VARMM procedure in place and used. Initial CMARAP on 17/07/15. Monthly multi-agency Briefing sessions from September 2015.
4	Effective response to concerns about service providers and prevention of abuse and neglect by working with service providers to promote dignity.	Further improved shared intelligence and responses to service provider concerns through the multi-agency Quality Control Panel, with an emphasis on working with providers to promote dignity, to prevent and respond to abuse and neglect.	Rob Persey/ David Parry	October 2015		Quality Board and Quality Control Panel in place. Revised provider concerns procedure drafted.
5	Effective deprivation of liberty safeguards to ensure that adults at risk who lack mental capacity do not have unreasonable constraints placed on their freedom.	Review the Deprivation of Liberty Safeguards service to further improve effectiveness in managing the substantial increase in referrals and assessments.	Clive Simmons/ David Parry	April 2016		Service review of DoLS system to be initiated. Initial planning of shared DoLS service with Richmond.

No.	Objectives	Actions	Responsible Officer	Timeframe	RAG Rating	Progress
6	Clear and transparent multi-agency quality assurance and performance monitoring to show that safeguarding outcomes are safe, proportionate and personalised.	Further develop a multi-agency quality assurance and performance monitoring dashboard, providing assurance to the Board and partner agencies that abuse and neglect are being prevented and that enquiry outcomes are safe, proportionate and personalised. This will include an increased emphasis on desired outcomes and on a range of audit approaches.	Sandra Storey/ David Flood	October 2015		Annual Report providing springboard for quarterly reports. Dashboard nearing completion and requiring increased multi-agency focus.
		Performance monitoring will include a focus on risk thresholds, substantiated outcomes, making safeguarding personal, BAME referrals, domiciliary care, care and nursing homes, and mental health inpatient wards, which are areas highlighted in 2014-15 quality assurance and performance monitoring.	Sandra Storey/ David Flood	October 2015		As above.

No.	Objectives	Actions	Responsible Officer	Timeframe	RAG Rating	Progress
7	A multi-agency workforce that is equipped with the skills to prevent, report and respond to abuse and neglect.	Further improved workforce training plan with new and improved courses. These will include advanced training on conducting safeguarding enquiries; achieving best evidence joint training with the Police; joint training to residents and staff in care homes on awareness of abuse and promotion of dignity; and continued briefings to Safeguarding Adults Managers, Social Work Teams and partner agencies on enhanced practice, alongside the promotion of team champions. There will also be a focus on training in mental health inpatient wards and to domiciliary care agency staff.	Sandra Storey/ Mark Barnard	October 2015		Training Plan 2015-16 in place and most training commissioned.
		Further improved management and reporting on multi-agency attendance at relevant training for competency levels; alongside clearer evaluation of the effectiveness of training on influencing improved practice.	Sandra Storey/ Mark Barnard	October 2015		As above

No.	Objectives	Actions	Responsible Officer	Timeframe	RAG Rating	Progress
8	Active engagement with the local community to ensure that the safeguarding service is responsive to the needs and aspirations of people in the borough, including BAME, faith and LGBT communities.	Completion of a bi-annual Wandsworth Safeguarding Adults Conference in the Town Hall Civic Suite, with a wide range of participants from across the borough, on the theme of implementing the requirements of the Care Act 2014.	Clive Simmons/ Mark Barnard	November 2015		Conference scheduled for 04/11/15 at Civic Suite on Care Act themes.
		Increased engagement with community groups to raise awareness and reporting of abuse, including BAME, faith and LGBT communities.	Clive Simmons/ Mark Barnard	November 2015		Information stands held on Wandsworth safeguarding week in June 2015. To develop improved community outreach contacts.

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