Wigan Council

This is an Open Report

Report to:	**ADULT HEALTH AND WELL BEING SCRUTINY COMMITTEE** **CABINET**
Date:	**2ND JUNE 2009** **18TH JUNE 2009**
Subject:	**ADULT SAFEGUARDING**
Report of:	**EXECUTIVE DIRECTOR: HEALTH AND WELL BEING**
Contact officer:	**BERNARD WALKER 01942 827780**

Purpose / summary:

Whilst safeguarding adults does not have the same legislative framework and drivers as in Children's Services, there is none the less, a growing recognition that this is an area which deserves equal attention particularly with regard to the personalisation agenda. This report provides a summary of the developments and activity of this area of work over the last 12 months.

Alternative options considered and reason for selecting the one recommended: N/A

Recommendation / decision:

Members are asked to accept the content of this Report together with the contents of the Annual Safeguarding Report.

The decision will be made as a result of this report and will be published within 48 hours

Risks / Implications:

Financial:	None
Staffing:	None
Policy:	None
Equal Opportunities - Has a Diversity Impact Assessment been conducted?	No
Wards affected:	All

Property Implications – Does the proposal involve a reduction, addition or change to the Council's asset base or its occupation?
No
If yes, have the property implications been agreed with the Corporate Property Officer?

Does this proposal have significant implications for the Council and the local population?
A diversity impact assessment is not necessary at this stage, however, equality and diversity implications have been considered when producing this report.
Does this proposal involve a new policy or procedure or significant changes to an existing policy or procedure?
A diversity impact assessment is not necessary at this stage, however, equality and diversity implications have been considered when producing this report.

Has the Service Director - Borough Solicitor confirmed that the recommendations within this report are lawful and comply with the Council's Constitution?	**No** *
Has the Service Director - Corporate Services confirmed that any expenditure referred to within this report is consistent with the Council's budget?	**No** *
Are any of the recommendations within this report contrary to the Policy Framework of the Council?	**No** *

* delete which applicable

For Cabinet reports only :

Categorisation of the report:	x
Discussion leading to a decision	
Monitoring	
Sharing for corporate understanding	

	x
Discussion	
Decision	
Information	X

Tracking/Process:

	Consultation	Ward Members	Partners
Panel / Committee	Overview & Scrutiny	Cabinet	Council
02.06.09.		18.06.09.	

There are no Background Papers to this Report within the meaning of Section 100D of the Local Government Act 1972.

Proper Officer Bernard Walker

Date 20th May 2009

1. BACKGROUND

Whilst safeguarding adults does not have the same legislative framework and drivers as in Children's Services, there is none the less, a growing recognition that this is an area which deserves equal attention particularly with regard to the personalisation agenda. This report provides a summary of the developments and activity of this area of work over the last 12 months.

2. SAFEGUARDING BOARD

2.1 There has been a growing recognition that Safeguarding is the responsibility of all stakeholders and not just that of Adult Services, and this is reflected in attendance and commitment to the Adult Safeguarding Board. For example there has been funding from the PCT to help develop the quality assurance infrastructure and the PCT representative is also the vice chair of the board. This year has been one of consolidation, reviewing multi-agency procedures, developing joint working, identifying and meeting stakeholder training requirements, and responding to national consultation documents as a board. There has also been increasing attendance at the Board meetings and there are representatives from a wide range of agencies including:

- PCT
- Health Trusts
- Housing
- Police
- Community Engagement
- Independent Providers and Voluntary Sector
- Adult Services

2.2 This joint approach is reflected in practice e.g. multi-agency strategy meetings, case conferences and shared information, all leading to a better co-ordinated safeguarding response.

There have been 3 key working groups under the remit of the Safeguarding Board:

- Marketing
- Training
- Review of procedures

Membership of these groups has been multi agency, and although led by DAS, there is clear ownership from all stakeholders.

2.3 The independent sector representative has been nominated by the Domiciliary Providers Forum to attend on their behalf. This is particularly valuable given that domiciliary workers are often at the front-line and can provide early alerts to potential abusive situations. In addition to this, it also demonstrates the breadth of stakeholders and the recognition given to the status of the board by non-statutory agencies.

3. CARE QUALITY COMMISSION

3.1 From a departmental perspective, the work is undertaken within the requirements of the Care Quality Commission (previously Commission for Social Care Inspection) and our performance is judged on how we achieve our outcomes in this area. Our last inspection deemed us adequate and that our confidence in improving was well founded. A representative from the Care Quality Commission attends the Safeguarding Board as well as attending regular Departmental meetings regarding operational issues. He has provided good support and advice and has endorsed that our approach is suitably robust. Furthermore there are now regular monthly meetings with CQC to help strengthen partnership working and to address particular concerns around services which are involved in safeguarding issues.

4. REFERRALS

4.1 We can demonstrate that we have raised the profile of safeguarding as we have seen an increase in the number of referrals made as well as the range of referrers. We have improved our information and data collection to monitor current need and response, and also to identify the most appropriate areas to address when developing our preventative strategies. The Annual Report provides a more detailed statistical breakdown of referrals and their source. We have also ensured that safeguarding has maintained a high profile by presenting the previous annual report to panel and cabinet thereby engaging with elected members.

5. MARKETING

5.1 To empower vulnerable people and to ensure they are able either to protect themselves, or know how to report their concerns, we have developed a marketing strategy to raise awareness within the general public. The first publication was in Borough Life in March. There has also been specific awareness raising through the Learning Disability Partnership Board and within the Department's Day Services. This was also an opportunity to discuss in a non-threatening way the different aspects of abuse, such as financial and mental abuse, which quite often is not considered.

6. LAA TARGETS

6.1 It has been recognised that vulnerable adults need to be better supported and involved in case conferences and decision making processes. With this in mind we have set LAA targets to increase involvement and to do this we pay particular attention to those with communication and specific care needs. We have also set LAA targets to ensure that any service user who comes into the case conferencing procedures is supported through a Protection Plan which focuses on keeping them safe following an incident. Current performance against these targets is good.

7. DOLS (DEPRIVATION OF LIBERTY SAFEGUARDS)

7.1 The structures for implementing DOLS and IMCAs (Independent Mental Capacity Advocates) are in place and DOLS sit firmly within the safeguarding processes. The Safeguarding Manager is routinely supported by the DOLS Co-ordinator/Mental Capacity Act Safeguarding Officer in case conferences. This person can act as an advocate, but also can also act as an independent person, providing information and advice regarding DOLS, where people who do not have capacity are supported by their relatives.

8. TRAINING

8.1 We have significantly increased training to the private and independent sector but need to increase engagement with the voluntary sector. We have developed good working relationships with the Care Quality Commission who stress training requirement when engaging with service providers during inspections. Whilst there is room for improvement with the uptake, it is clear that there has been recognition from providers that this is an important area to address. Training for professional staff has been refreshed and there is a number of different courses to reflect the requirements of specific roles. There has been increased uptake of training from health colleagues but needs this needs to increase even further; we also need to widen access to training to include members of the voluntary sector.

9. QUALITY ASSURANCE

9.1 We have developed a robust quality framework which draws together quality assurance, complaints and safeguarding procedures. This provides a strong foundation for the requirement of 'Transforming Social Care' where it is anticipated that there will be more positive risk taking, and stakeholders will need to have confidence in the services they may be arranging for themselves. With this is mind there is also a project mandate under the Transforming Social Care Action Plan to further develop risk assessment and risk management process which help people to remain safe wherever they chose to live and whatever the funding source.

9.2 Bringing together sources information provides us with an early warning system of poor practice or institutional abuse and the quality assurance approach takes into account the importance of contractual relationships. All private providers are required to have safeguarding procedures and to have staff CRB checked and action is taken immediately on any suspicion of poor performance or institutional abuse.

10. GROWTH AND USE OF EXISTING RESOURCES

10.1 The Department of Adult Services recognised the importance of safeguarding and secured growth of £98K. This was supplemented by additional on-going £50K from the PCT to develop an infrastructure which could provide the appropriate safeguarding support services. The contribution from the PCT demonstrates the partnership working that has emerged and developed over the last 18 months. This funding has supported the development of an infrastructure which is proving to be invaluable. The Safeguarding Manager is providing consistent and useful advice to all stakeholders and is ensuring that the quality of conferences and strategy meetings are of a good standard. The subsequent appointments to Deputy Manager and Support Officer will enable safeguarding service to develop in a more structured and strategic way through the provision and analysis of detailed information on which to base our plans.

10.2 The Police have also appointed a Safeguarding Officer who, together with the Safeguarding Manager, has made a significant impact on the quality of the safeguarding process.

10.3 We look to take opportunities wherever possible to increase the safeguarding of vulnerable people. For example we are also working within Business Support colleagues in Audit who provide advice regarding the robustness of our appointeeship processes and provide an expert and independent challenge to our practices. This has undoubtedly helped to improve the quality of the service we provide to vulnerable people as well as demonstrating the importance of our 'back-office' functions in supporting members of the public. We have also developed links to voluntary groups, such as Age Concern, who provide a route into our services should the need arise and will provide support and advocacy during safeguarding investigations. We proactively use Supporting People and Assistive Technology funding to promote safety at home in its broadest sense.

11. ACHIEVEMENTS

11.1 The Safeguarding Board has developed a good momentum with a clear action plan and activity and commitment from all stakeholders. The Board has focussed primarily on 7 key actions which in most cases have been delivered by Adult Services on the Board's behalf. Further details of this are included in the Annual Report.

11.2 We have compared ourselves with Bolton Council which has been assessed as being excellent with regard to their approach to safeguarding and there are a number of practices highlighted in which Wigan has similar activity, including:

- Multi-agency working
- Prompt response to possible institutional abuse
- Robust quality assurance processes
- Clear links to DOLS and IMCA
- Multi-agency training
- Review and audit of processes

It has highlighted however areas for further development, for example, supporting people from diverse communities, consistency in the application of safeguarding procedures and development of supported risk taking approaches. We have made links with Bolton and plan to meet in the near future to address these issues.

11.3 Our current achievements and outcomes have focussed on being responsive. We have:

- Developed a new Safeguarding Team
- Strengthened multi-agency working
- Increased membership of Safeguarding Board
- Raised awareness in private and voluntary sector provision as well as in statutory services
- Used existing service provision to informally raise awareness with vulnerable service user groups
- Increased referrals
- Good performance on LAA indicators
- Improved data collection
- Improved consistency of use of procedures (although further improvement needed)
- Developed and implemented training across all sectors with good up-take
- Developed marketing strategy
- Established links with safeguarding and quality assurance
- CQC involved in operational issues for advice and guidance

We are confident as a result of these achievements we are delivering good safeguarding services to the people of Wigan. Those who, unfortunately, may find themselves within the system are treated with respect and dignity and are supported according to their specific needs. Individuals can be confident that there is good communication between the parties involved and that staff and agencies are competent in this area of work.

12. FUTURE ACTIONS

12.1 It is clear that we have reached a watershed in safeguarding. We have developed a strong framework for safeguarding but up till now much of the work has been about responding to situations; we now aim to develop the preventative aspects of safeguarding and the associated outcomes.

Preventative outcomes can be achieved through:

- Proactive approaches to help stop abuse
- Establishing firm links with ‘Building Stronger Communities’
- Increasing service user involvement in developing accessible information, advice and procedures
- Using data and intelligence to achieve best outcomes

12.2 The Board has developed its Action Plan and a facilitated away-day has been planned for August to agree commitment and resource implications for all stakeholders.

13. **CONCLUSION**

13.1 It is at this stage that the Council should consider safeguarding in its wider context and we should maximise the links with Building Stronger Communities and the development of Universal Services. The concept of safeguarding has clearly grown from responding to situations to include preventing such occurrences in the first place. For this to happen there needs to be a strong strategic approach which draws on the support of the community at large, as it is only through this means that we can keep people safe in the broadest sense. We will therefore strengthen connections with the Building Stronger Communities agenda to ensure there is a robust approach to safeguarding. This should draw in the general public through neighbourhood work, as well as the work led by the Department of Adult Services. Borough-wide involvement in safeguarding will ensure that those who are vulnerable or at risk, or who may be on the margins of targeted services, are more able to access support and advice through a range of ordinary services which do not focus solely on social care but will protect vulnerable people from harm.

14. **RECOMMENDATIONS**

14.1 Members are asked to accept the content of this report together with the contents of the Annual Safeguarding Report.

wigan adult safeguarding board

WIGAN BOROUGH
Adult Safeguarding Board

Annual Report

2008 – 2009

Adult abuse happens.
Help us prevent it.

Neglect, deception, exploitation, intimidation, physical and sexual abuse.

Some people cannot protect themselves.
They need your support.

Visit **www.wigan.gov.uk/adultabuse**
or call **01942 828777** for more information.

Authors **G. Ellis**
E. Lamprell

May, 2009

1) Introduction

This report is produced annually for Wigan Borough's Adult Safeguarding Board to enable it to review activities undertaken on its behalf over the year. It comments on progress made in the implementation of last year's Action Plan and suggests an appropriate Action Plan for the coming year.

The monitoring of activities and identification of relevant issues adds to the ability of the Safeguarding Board to have a strategic overview of relevant safeguarding issues, to consider necessary strategies and direction for safeguarding in the future and to monitor the effectiveness of those strategies in achieving desired outcomes.

The report provides evidence of the way the system has worked during the year and identifies key issues for further consideration. Whilst specifically written for the Board, the report needs to be discussed fully within all partner agencies and absorbed into their service planning processes. It is only if all partner agencies fulfill our joint responsibilities to safeguarding that we will be able to provide a safe and robust system that not only protects vulnerable adults from abuse but actively works to prevent abuse from occurring in the first place.

2) Headline Comment

There has once again been an increase in the total number of referrals made over the year. This has risen from 304 to 313 (3% increase) and is consistent with the picture from other authorities. Whilst it is perhaps too early in the development of safeguarding to completely explain the reasons for this continued increase, it is thought that the work undertaken to increase awareness of safeguarding and a greatly improved administration system for obtaining information have made significant contribution. Awareness has been promoted through the training programme, closer liaison with partner agencies and improved mechanisms to provide feedback about practice. The appointment of a support officer has led to a much improved system of data collection and ability to "chase up" returns when necessary.

Tables of statistics can be found in Appendix 1 but within these figures, the headlines are:-

- Reduction in referrals for people with learning disabilities (57-49)
- 150% increase in referrals for Physical Disabilities Team, Under 65 Hospital Discharge Team and Sensory Disabilities Team (16-40)
- Increase from 101 to 119 for Mental Health Teams (18%)
- Older People (including over 65's Mental Health) remain the largest single group of people referred (183 or 58%). This group has consistently provided around two thirds of all referrals over the last three years.
- Of completed cases, 100 were closed without need for investigation.

As a direct result of the appointment of the support officer and improvement in administrative systems, it is possible to identify more information about case conferences and Strategy Meetings (see below). There were 119 Strategy Meetings held which were followed by 60 case conferences.

It is pleasing to note that there was a significant increase in the number of relatives attending case conferences and approximately 60% of all case conferences held had a family member at them.

There has been significant movement made towards monitoring the quality of the safeguarding service provided. Particular problems have been experienced within Mental Health, primarily due to staff shortages and the number of cases referred. As a result of difficulties, two complementary "reviews" have been undertaken and agreement has been reached on ways forward to support and improve the response to safeguarding within this area. One reviewed case conferences and the other general practice. Recommendations made as a result are entirely consistent with activities already being undertaken to improve safeguarding. They have led to the identification of lead officers within teams regularly meeting with the Safeguarding Manager and reinforcement of procedural requirements with staff. Priority will also be given by the Deputy Manager to chair conferences within mental health to ensure consistency of practice.

Following last year's report, an Action Plan containing 7 specific actions was agreed and at the time of the May meeting, 3 of the 7 actions have been completed fully, 3 have mostly been completed and 1 should be completed in the near future. (See below).

3) **Statistics**

- **Referrals**

  Since last year, significant progress has been made to use the SWIFT database of Adult Services Department for safeguarding purposes. This has meant that adjustments have to be made to meet the requirements of safeguarding data collection and this work is ongoing. However, combined with other work initiated by the support officer, we can collect more and better information whilst being more confident about its accuracy and relevance for monitoring requirements. A practical example of this is an updating of last years figures to a total of 304 referrals rather than 270 previously reported.

  There remains inconsistencies in the return of appropriate forms between social work teams, but difficulties have been addressed with relevant managers and improvement evidenced as a result.

- **Nature Of Abuse**

  As with last year the most recorded type of alleged abuse investigated was physical abuse.

  - 38 (31%) Physical Abuse (47% last year)
  - 28 (24%) Financial Abuse (22% last year)
  - 23 (19%) Neglect (11% last year)
  - 21 (18%) Psychological (7% last year)
  - 7 (6%) Sexual (8% last year)

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Location

As with last year, the majority of investigated abuse occurred within a person's own home. This consisted of 66 (55%) of all cases investigated. The next highest category was within Care Homes (38 or 32%).

- **Source Of Referral**

Improvements to the administration system used has meant that we can clearly identify the source of referrals. Historically this has been distorted as social workers had recorded themselves as the source given the format of the forms used.

Interestingly, 38 (or 12%) of all referrals were from the person allegedly being abused but the highest source were professional carers (whether providing care at home, in residential care or day care). These referred 64 (or 20%) of all cases. The second highest source for referrals were relatives (52 or 17%) closely followed by Care Home Managers and Police (32 or 10%), and then social workers (27 or 9%),

The source of referrals demonstrate the importance of raising awareness about safeguarding within the community (the source of a third of all referrals) as well as with partner agencies.

- **Strategy Meetings**

At present, the SWIFT software package can only be used to provide detailed information once a Strategy Meeting has been held and social workers then input information onto the system. Changes planned for data collection will enable more detailed information to be provided next year.

Of the 119 Strategy Meetings held, decisions were made to hold case conferences in 60 cases. Reasons were given for not proceeding to conference with the remaining 59 cases however, and analysis of reasons given for this has led to some concerns about practice. There appears to be reasons for challenging these decisions in a number of cases e.g:

- Insufficient evidence (20)
- Service User refused (10)
- Abuser dismissed (1)
- Care Worker disciplined according to agency care procedures and Service Users family satisfied with outcome (1)
- Issue dealt with at investigation stage and Protection Plan in place (1)
- Agreed with husband and line manager that it was a one off incident brought on by frustration with caring for wife who has dementia (1)

It is quite possible that all reasons are valid but on the face of it this does not appear to be the case.

- **Case Conferences**

The Deputy Manager started in post on 4th May, 2009 after the previous appointment withdrew and two further advertisements were necessary.

Fortunately, it has been possible to prepare key actions with her prior to appointment and it is expected that she will hit the ground running.

There has been marked success in improving the attendance of relatives at conference with approximately 60% of conferences having relatives present. The impact of the Support Officer in respect of monitoring a number of conferences has also led to improvement (see Administration)

- **Residential And Nursing Home Referrals**

There were 56 referrals involving people living in Residential and/or Nursing Homes of which 32 (51%) were within mental health services and 14 (25%) were older people.

Of the referrals made, 33 (59%) were allegations regarding staff; 12 (21%) regarding relatives or friends; 8 (14%) were regarding other residents and the rest were regarding “unknown” abusers.

4) Multi - Agency Working

The dedicated officer for adult safeguarding appointed by the Police has continued to make a significant impact on safeguarding practice within the borough and has witnessed a significant growth in relation to demands made on her. She has continued to meet regularly with the Safeguarding Service Manager, and working relationships have strengthened as a result. Police are now more involved in the Safeguarding process and at an earlier stage.

Meetings have also been held with Police colleagues to consider wider issues of safeguarding and future developments.

Monthly meetings with the regional regulatory manager from C.S.C.I. have continued throughout the year and have proved to be mutually beneficial. It is hoped that the replacement of C.S.C.I. by the Care Quality Commission with subsequent changes in structure and responsibilities do not undermined these arrangements as they have enabled the sharing of information about areas of concern and a joint approach being applied to the monitoring of specific care homes. These included a joint meeting with colleagues from Salford to compare services.

Discussion about operational issues and necessary changes within Mental Health Services have led to Adult Services Department and P.C.T. altering an existing post leading on D.O.L.S. (Deprivation of Liberty Safeguards), to have specific responsibilities with adult safeguarding; increase of further half time I.M.C.A. (Independent Mental Capacity Advocate) post and; identification of funding to provide training in respect of Mental Capacity/DOLS issues which will now relate these to safeguarding. Practical support has also been provided to operational staff to help in responding to referrals. These developments have strengthened the “independent” support for people going through the safeguarding process, contributed to awareness raising of D.O.L.S. issues and will help in moves towards an emphasis on prevention of abuse.

The Safeguarding Service Manager attends regular meetings of the local authorities' Greater Manchester Forum of Adult Safeguarding Service Managers. This allows the sharing of information and benchmarking activities that are so important to ensure Wigan's developments are in accordance with contemporary best practice. It has also led to Wigan being able to amend forms etc to meet present and future needs.

There has been presentations made to:-

- Wigan and Leigh Housing and their Sheltered Accommodation Managers. This has influenced the development of their own in house training package.
- Learning Disability Partnership
- Clinical Psychologists based at Leigh Infirmary which has resulted in a greater understanding of how they can assist in cases where capacity and cognitive function may be a factor for people (e.g. with a learning disability or brain injury) in participating in a case conference.
- Domiciliary Care Providers Forum which was used to promote the department's training and has led to a representative from this group joining the Safeguarding Board.

Apart from specific presentations, the Manager regularly attends meetings of Adult Services Department Managers to promote activities, increase awareness and provide feedback on the service. She also takes every other opportunity to attend other meetings and use them to promote and develop services. For example meeting with the Adult Services Contracts Section and thereafter checking contracts to ensure inclusion of required safeguarding policies and procedures.

Wider issues raised by safeguarding investigations are also being pursued more effectively with home owners to ensure quality of care provided to residents.

5) <u>Administration</u>

The appointment of a Support Officer (0n 20th October, 2008) means that we can include specific comment under this heading for the first time and produce evidence of the impact she has made on the service.

The support provided to the Safeguarding Manager and joint activities that follow have led to more user friendly forms being introduced (i.e. Trigger Form and Monitoring Form and more accurate data being collected accordingly). The Support Officer has also:

- Met regularly with members of the SWIFT team to ensure data can be collected accurately.
- Devised new filing systems
- Developed protocol for quick return of data forms
- Enabled greater consistency in the recording of information
- Taken minutes at 14 Strategy Meetings, 18 Case Conferences and 6 Professional Meetings which reduced the pressure on other operational staff whilst enabling accurate recording and clear audit trails to be produced.

We can now be more confident that appropriate data will be recorded and recorded accurately.

6) Training

The previous lead for adult safeguarding training left the Council and structural changes have led to relevant training being the responsibility of the newly created Learning and Development section of the Chief Executives' Department. The training programme has continued to be provided by the Chief Executives' Department.

Changes have inevitably impinged on the work undertaken by the Training Sub Group and its ability to produce the Training Strategy identified as being necessary in last years' Action Plan. Much progress has been made in respect of the strategy and strenuous efforts made to ensure we do not lose the momentum built up in this area.

A separate report on Training will be produced for the Safeguarding Board.

7) Marketing And Publicity

A separate Marketing Strategy report will be presented to the Safeguarding Board alongside this report. Phase 1 of the Strategy has seen the acceptance of a logo for the Board and a front sheet for future publicity. An article has also been published in the Council's Borough Life magazine.

The importance of marketing and publicity to the cause of safeguarding cannot be underestimated - particularly if we are to move further into the area of preventing abuse rather than just responding to it. A series of new leaflets and publicity material will be produced over the forthcoming year.

8) General Comments

Once again the year has seen an increase in the number of cases referred, many of which are very complex and challenging. We are making progress in our understanding of adult abuse and appropriate ways of responding to it. Individual cases have been used to improve practice and there has been a major shift made in respect of our ability to monitor safeguarding and provide informative data on which to build future activities.

As a result of activities undertaken by individual agencies and within multi-agency working arrangements, it is clear that more people are becoming aware of safeguarding issues and referring cases for investigation. Because of this and subsequent action taken, more people are being protected from harm or possible harm.

It is of particular benefit for safeguarding to have strengthened its ties with the Quality Assurance mechanisms that are being developed within the Adult Services Department. This will inevitably increase the impact of safeguarding issues and enable feedback from cases to the broader development and monitoring of quality services.

All Action Plans, have not been achieved within timescale but we have made significant progress in those outstanding. We are optimistic about the future and believe that the completion of appointments to posts will witness significant improvement in practice and the monitoring of that practice.

It is thought that Safeguarding in Wigan has now reached a watershed and the Safeguarding Board will need to consider a number of strategies to determine future direction and priorities. We have responded positively to provide staffing and structure for a Safeguarding Service Support Team. This has provided a strong base for us to meet immediate operational requirements, monitor practice and produce accurate data to inform improved practice and new strategies. We must build on this by creating a new vision which builds on our experience, but looks to the future and pre-empts likely outcomes from the review of No Secrets. The vision should sit alongside complementary strategies such as those agreed within the Local Strategic Partnership. Safeguarding must not be seen in isolation from other strategies (e.g. Community Strategy; Building Stronger Communities etc.).

In this context, it is suggested that two Annual Reports are produced next year. A report providing feedback on how safeguarding works in practice within the Borough (similar to this report) and another which takes a more strategic view of safeguarding and how the Safeguarding Board has fulfilled its purpose as described in the Business Plan and Constitution .

To help this process and in anticipation of agreement to it, this report will be called "Annual Report Of Safeguarding Support Service" in future and the structure agreed by the Safeguarding Board will be called the "Safeguarding Support Service".

Future priorities for the Safeguarding Support Service, agreed by the Safeguarding Board will therefore complement priorities of other agencies and broader priorities of the Board. These should all be incorporated into the Action Plan for the forthcoming year.

9) Future Plans

Whilst commenting on future plans, it is essential to remember that these will be actioned in the knowledge that the day to day business of safeguarding has to operate efficiently and effectively. We must respond to allegations of abuse and protect vulnerable adults at risk when necessary, whilst looking to the future.

Part of work necessary for the future is to clearly identify the intended outcomes that follow activities undertaken by the Safeguarding Support Services on behalf of the Board.

It is thought that we have a good basis (for the first time) of dealing with immediacy of abuse (subject to operational demands on agencies). We must continue to build on that base and monitor practice whilst improving inter-agency working. This must be undertaken within a new emphasis of using our knowledge and working relationships to prevent abuse occurring in the first place. This will require appropriate resourcing for the Board's Marketing Strategy and development of closer links with Township and other groups working within the community.

The Action Plan (Appendix 2) outlines the main priorities for the forthcoming year.

Appendix 1

Figures for 1st April 2008 – 31st March, 2009
Safeguarding Annual Report

1) Referrals Over 4 Year Period

Client Category	01/04/05 to 31/03/06	01/04/06 to 31/03/07	01/04/07 to 31/03/08	01/04/08 to 31/03/09
Older People				
Number of referrals	6	60	93	105
Number of completed cases	6	54	73	97
Learning Disabilities				
Number of referrals	2	21	57	49
Number of completed cases	2	16	41	35
Physical Disabilities, Under 65's Hospital Discharge Team and Sensory Disabilities				
Number of referrals	2	12	16	40
Number of completed cases	2	8	13	34
Mental Health Over 65's				
Number of referrals	N/K	31	66	78
Number of completed cases	N/K	19	31	41
Mental Health Under 65's				
Number of referrals	5	12	35	41
Number of completed cases	5	9	20	12
Substance Misuse				
Number of referrals	0	0	2	0
Number of completed cases	0	0	0	0
Carers				
Number of referrals	0	0	1	0
Number of completed cases	0	0	1	0
Total				
Number of referrals	**15**	**136**	**304**	**313**
Number of completed cases	**15**	**106**	**179**	**219**

"Completed cases" refer to those investigations which have been closed during the period and for which monitoring forms have been received. Of the completed cases 100 were closed as No Further Action. 119 cases progressed to investigation.

There was a total of 331 referrals as 18 referrals were not allocated to a Team from CDT and advice was given.

2) Residential and Nursing Home Referrals

Client Category	
Older People	14
Older People Mental Health	32
Learning Disabilities	6
Physical Disabilities	4
Total no of referrals	**56**
Allegations regarding staff	33
Allegations regarding relatives/friends	12
Allegations regarding fellow residents	8
Allegations regarding unknown abuser	3

3) Nature of Abuse

Physical	38
Discriminatory	1
Financial or Material	28
Psychological	21
Neglect or Act of Omission	23
Sexual	7
Verbal	1
Enforcement against a persons wishes	0

4) Source of referral:

Self	38
Home Care	45
Day Care	4
Residential Home Carer	15
Police	32
Relative	52
Housing	11
Nurse / Ward Staff	15
Other Local Authority	3
Accommodation Managers / Assistant Accommodation Managers	7
Care Home Manager	32
CSCI	2
Financial Assessment Team	3
Finance	3
G.P	3
Community Matron	3
Anonymous	2
Friend / Neighbour / Befriender	11
Social Worker	27
Warden	3
Supported Living Service	1
College	1
Total	**313**

5) Location of Abuse

Victims Home	66
Care Home	38
Hospital	1
Alleged Abusers Home	2
Sheltered Accommodation	5
Extra Care Housing	2
Respite Accommodation	1
Other	4

Wigan Adult Safeguarding Board

Support Services Action Plan 2009 – 2012

This Action Plan is based on information contained in the 2009 – 2010 Annual Report. It should be complemented by Action Plans of partner agencies and inform a Strategic Action Plan agreed by the safeguarding Board.

Action Required	**Lead Person**	**Others Participating**	**Completion Date**
Complete recruitment of Support Services Staff.	G. Ellis	E. Lamprell and rep from another agency	September, 2009
Distribute and launch completed Multi- Agency Procedures.	G. Ellis	Members of Procedures Sub-Group	July, 2009
Implement Marketing Strategy as far as available resources allow.	E. Lamprell	Members of marketing Strategy Sub-Group	Ongoing throughout the year.
Complete Training Strategy and implement.	S. Adams/ E. Lamprell	Members of Training Sub-Group	Ongoing throughout the year
Initiate contact with Townships and other Community Groups to raise awareness and move towards development of “Prevention Strategy”.	E. Lamprell/ G. Ellis	Partner agencies as relevant	Prevention Strategy to be completed by May, 2010
Review Case Conference practice and produce new forms and guidance.	E. Lamprell/ L. Durkin	Members of the Procedures Sub. Group	November, 2009
Review data collection requirements and amend systems to ensure data meets needs of the Board.	E. Lamprell/ L. Fletcher	Partner agencies as relevant	July, 2009

Arrange visit to Bolton Council to address issues of good practice.	J. Jeffers/ G. Ellis	E. Lamprell	August 2009