City and Hackney Safeguarding Adults Board Annual Report 2013/14

City and Hackney Clinical Commissioning Group

East London NHS Foundation Trust

Homerton University Hospital NHS Foundation Trust

Working together for a Safer London

Older People's Reference Group
City & Hackney Older People's Board

In partnership with Hackney Council

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Foreword by the Chair of the Safeguarding Adults Board

I am pleased to introduce this fifth annual report of the City and Hackney Safeguarding Adults Board (CHSAB). The report provides an insight to our adult safeguarding work, addresses current local and national challenges and highlights the progress made in the City and Hackney over 2013/14.

We have strong partnerships locally and innovative processes to identify and safeguard adults at risk. Our work over the last year has set the foundation for a high quality partnership to meet the safeguarding requirements arising from the implementation of the Care Act and the report reflects the commitment of Board members and their organisations to work collaboratively towards our common vision:

> *People should be able to live a life free from harm in communities that are intolerant of abuse, work together to prevent abuse and know what to do when it happens.*

The quality of health and social care services has continued to be a subject of national concern over the last year. Nationally the number of people in England who have a health problem requiring health and social care is increasing with a growing likelihood of more people with complex needs requiring a combination of social and health care services. This national picture is reflected in the developing demography of City and Hackney.

The themes addressed within this year's annual report include: the developing framework of joined up working with local partners; providing a personalised, responsive, quality service which listens to and meets the needs of our diverse service users in promoting their independence and safety; and ensuring that service users are able to identify, report and understand how to manage the associated risks if they are being abused.

Here is an account of last year's work. We would welcome your feedback on last year's work and any suggestions for what the Board should be doing in future. Please pass on any comments to the Safeguarding teams in your local authority (see the appendices for their contact details).

Fran Pearson
Independent Chair

Introduction

High quality adult safeguarding systems are in place in the City and Hackney. Under the stewardship of the City and Hackney Safeguarding Adults Board, these systems and services continue to protect adults at risk from abuse and harm and support community safety.

The term 'safeguarding' is used to mean both specialist services where harm or abuse has, or is suspected to have, occurred, and other activity designed to promote the wellbeing and safeguard the rights of adults. In its broadest sense safeguarding is everybody's business: the public, volunteers and professionals. It covers a wide range of activities and actions taken by a large number of people, not least by people in the community.

This annual report describes the current arrangements for ensuring the safety of "adults at risk" in the borough and provides an assessment of the key developments in local multi-agency adult safeguarding systems in 2013/2014 along with a statistical analysis of the casework activity and reports from individual agencies.

The Board has followed current government guidance in considering an adult at risk to be someone aged 18 years or over "who is or may be in need of community care services by reason of mental or other disability, age or illness: and who is or maybe unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation" (DOH, No Secrets, 2000). The Board notes however that implementing the Care Act (see below) may have an impact on the numbers of people for whom safeguarding enquiries will be necessary. This will be analysed in next year's annual report.

2 Developments in National and Local Policy in 2013/14

2.1 The Care Act 2014

The Care Act which received Royal Assent in May 2014 sets out the statutory framework for adult safeguarding. Central to the Care Act is the concept of wellbeing, which means we have a duty to consider the physical, mental and emotional wellbeing of people needing care. This is underpinned by an emphasis on prevention. The Care Act brings in stronger regulatory powers, including prosecution where necessary, and the Chief Inspector of Social Care will be able to hold providers of care to account when they provide poor care.

The Care Act sets out the requirements for the establishment and functioning of Safeguarding Adults Boards. The specific duties of the Board will include:

- To agree and keep under review multi-agency safeguarding adults policies and procedures for the protection of adults-at-risk, taking into account statutory requirements, national guidance and London regional policies.

- To maintain an Annual Business Plan setting out priorities for preventing and addressing abuse of adults-at-risk, and to produce and disseminate an Annual Report.

- To monitor incidents of abuse and neglect, review trends and take action where appropriate to improve services and support to adults-at-risk.

- To regularly evaluate how agencies and providers are performing in relation to safeguarding adults, operating rigorous quality assurance and scrutiny systems across partner agencies.

- To agree a Safeguarding Adults Review Protocol and review and learn from situations where safeguarding arrangements may not have been adequate.

We responded to consultation on the regulations and statutory guidance which was published in October 2014 and our business plan will be ready for implementation when the Care Act takes effect in April 2015.

2.2 Mental Capacity Act 2005: House of Lords post-legislative scrutiny report

In March 2014 the House of Lords Select Committee on the Mental Capacity Act published its post-legislative scrutiny report. The Committee concluded that so far the potential of the Act to bring about real change in the support and protection of people who struggle to make their own decisions had not been realised.

The main findings of the Report are as follows:

- The ethos of the Mental Capacity Act is widely welcomed but it has not been adequately implemented due to lack of "ownership" by a dedicated independent oversight body;

- Too much decision-making in health and social care is still motivated by paternalism and risk-aversion rather than the principles of the Act;

- There is a lack of adequate information for all stakeholders – individuals, family members, professionals – leading to confusion over rights, roles, and responsibilities;

- The Deprivation of Liberty Safeguards are not working and need to be replaced;

- The Court of Protection needs more resources and should place more emphasis on mediation prior to court action.

In its response to the report the Government acknowledged many of the concerns raised by the House of Lords. The Government has set up a Mental Capacity Advisory Board and will seek to work with partners such as NHS England, ADASS and CQC to implement the Act more effectively. The Government has also asked the Law Commission to review the operation of the Deprivation of Liberty Safeguards (see below) and will provide more resources to the Court of Protection.

2.3 Deprivation of Liberty – the "Cheshire West" Supreme Court Decision

- In March 2014, a Supreme Court judgement known as the "Cheshire West" decision changed the criteria for assessing whether a person lacking mental capacity is being "deprived of their liberty" in a care home, hospital or other care setting. The judgment overturned a number of previous rulings from the Court of Appeal which had progressively restricted the application of the Deprivation of Liberty Safeguards (DoLS).

- The judgement has led to a significant increase in the number of capacity assessments for people with cognitive impairments who are held to require formal authorisation of "deprivation of liberty", either under: a) the deprivation of liberty safeguards (DoLS) (for hospital patients and care home residents), b) through the Court of Protection (for people in supported living schemes and some other community-based arrangements).

- The judgement introduced an "acid test" to identify deprivation of liberty in cases where a person is deemed to lack the capacity to give valid consent to their care arrangements. There are two key questions in the test: (1) is the person subject to continuous supervision and control, and (2) is the person free to leave?

- If the answer to both questions is "yes", then the person would now be considered to be deprived of his/her liberty and in need of the protection of an appropriate legal framework. Under previous case law deprivation of liberty was deemed to occur only when there were aggravating factors such as the person or their family objecting, high levels of restraint etc.

- This means that more people in care homes, hospitals, independent supported living schemes, mental health hospitals and institutions require assessments in order to consider whether they are being "deprived of liberty" and whether this is in their best interests. This has already seen significant financial and operational implications for the local authority overseeing the process and for service providers.

- The "Cheshire West" judgment was handed down at the very end of the year under report and had minimal impact on DoLS in City and Hackney in 2013-2014. It is already clear however that the situation for 2014-2015 will be very different. Full details will be given in next year's report.

2.4 Making Safeguarding Personal

- Making Safeguarding Personal is a sector led initiative in adult safeguarding. It has arisen in response to findings from peer challenges, the response to the 'No Secrets' consultation and other engagement with councils and their partners. It aims to develop outcomes-focused, person-centred adult safeguarding practice and a range of responses to support people to improve or resolve their circumstances. This should result in safeguarding being done with, and not to, people. This is in keeping with the focus on individual well-being promoted by the Care Act.
- City and Hackney are both committed to implementing Making Safeguarding Personal. The authorities' work to implement the Care Act will draw on the principles and resources of the MSP programme to ensure that staff have the skills and expertise to engage with service users and support them to achieve their preferred outcomes wherever possible.

2.5 Changes in the Care Quality Commission (CQC)

- In the past year, the CQC have made significant changes to the way they inspect and regulate health and social care services to make sure services provide people with safe, effective, compassionate and high-quality care, and to encourage them to make improvements.
- CQC's Strategy for 2013 -16 outlines the changes that apply to many services regulated by the Commission.
- During 2013 – 14, national teams have been introduced to inspect NHS hospitals and mental Health Trusts.

2.6 Response to Winterbourne View

- In December 2012, the Department of Health published "Transforming Care: A National Response to Winterbourne View Hospital, Department of Health Final Report. This report made a number of recommendations aimed at strengthening accountability and corporate responsibility for the quality of care and defined actions for the Department of Health, CQC, secure services, including prisons, the police, LGA, Healthwatch, as well as health and social care services.
- The Department of Health Report was followed by the launch of the "Winterbourne View Concordat and the Interagency Programme of Action". Locally, a working group was convened to ensure that the national targets

applicable to local health and social care agencies were met. This included commissioning and provider staff from Hackney Council, Homerton University Hospital Staff who are part of the Learning Disabilities Integrated Team, North East London Commissioning Support Unit, East London Foundation Trust.

- The targets were:
  a) All individuals placed in in-patient units to be reviewed by June 2013 and any users placed in hospital inappropriately to be moved to community-based support as quickly as possible, and no later than June 2014.
  b) Each area to have a joint plan in place by April 2014 to ensure high quality care and support services for all people with learning disabilities, autism and mental health conditions or 'challenging' behaviour, in line with best practice.

3 Safeguarding arrangements in the City & Hackney

3.1 What is the City & Hackney Safeguarding Adults Board?

The City and Hackney Safeguarding Adults Board (CHSAB) is a non-statutory multi-agency partnership that has a remit to protect adults-at-risk from abuse, neglect and significant harm. The Board seeks to bring about positive outcomes for adults-at-risk who live within the area of the City of London and the London Borough of Hackney, or who live outside the borough as a result of a placement made by the City of London, Hackney Council, North East London NHS Cluster or the East London Foundation Trust.

The Board has membership from a wide-range of partners including: City and Hackney Local Authorities, Health Services, Police, Probation, Fire Service and local community and voluntary sector organisations.

The Board co-ordinates the activities of each agency represented on the Board for the purposes of safeguarding adults in the City and Hackney. It also ensures the effectiveness of what is done by each person or agency that contributes to safeguarding adults in the area.

Our preparations for the implementation of the Care Act have gathered momentum over the last year and are reported later in this report. The core membership of the Board already includes all agencies required by the Act. The specific duties of the Board arising from the Act are set out in more detail in the previous section.

3.2 Community Safety: MAPPA and MARAC

The Home Office defines community safety as:

> *"An aspect of quality of life in which people, individually and collectively, are protected as far as possible form hazards or threats that result from the criminal or anti-social behaviour of others and are equipped or helped to cope with those they do experience."*

City and Hackney Safeguarding Adults Board have identified crime and fear of crime and antisocial behaviour as a key concern.

Safeguarding partners support the Community Safety Partnership in addressing issues of concern to reduce crime and antisocial behaviour in the borough.

Key areas of work include:

- Co-ordinated action to tackle antisocial behaviour through the joint Council and police Community Antisocial Behaviour Action Panels (ASBAP).
- Co-ordinated action to address domestic abuse, sexual violence and exploitation (MARAC) including victims of domestic violence, to keep them safe in their homes and reduce burglary.
- Work to reduce reoffending through the Multi Agency Public Protection Arrangements (MAPPA) and Integrated Offender management Scheme (IOM).
- Support for the process of analysis of crime and antisocial behaviour to direct the partnership's strategic and operational responses to tackling crime and antisocial behaviour.
- Media and advertising activity on behalf of the partnership to keep residents and visitors informed and advised on how to stay safe

The **Multi Agency Risk Assessment Conference** (MARAC) is part of a coordinated community response to domestic abuse, which aims to:

- Share information to increase the safety, health and wellbeing of victims/survivors – adults and their children.
- Determine whether the alleged perpetrator poses a significant risk to any particular individual or to the general community.
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- Reduce repeat victimisation
- Improve agency accountability: and
- Improve support for staff involved in high- risk domestic abuse cases

Multi Agency Public Protection Arrangements (MAPPA) are a statutory set of arrangements which bring together the police, probation and prison services to support the assessment and management of risks posed by the most serious offenders in order to protect the public and reduce the serious re-offending behaviour of violent and sexual offenders. Other agencies that deal with offenders, including local authority housing departments, social services and youth offending teams are under a 'duty to cooperate' with the MAPPA .

The aim of MAPPA is to ensure that risk management plans drawn up for the most serious offenders benefit from the information, skills and resources provided by the individual agencies being co-ordinated through MAPPA.

There are four key elements:

1. Identifying offenders to be supervised under MAPPA
2. Sharing information about offenders
3. Assessing the risks posed by offenders
4. Managing the risk posed by individual offenders

Case example Mrs W: How safe do service users feel in Hackney? (based on service user survey)

The following case relates to Mrs W, a 77 year old woman who had brought up her grandson A, since he had been a baby. A, has a mental health diagnosis and had developed drug and alcohol misuse issues which had resulted in him verbally, financially and emotionally abusing his grandmother. Police had been called and a restraining order had been placed on A as a consequence of a number of incidents that had happened in the home.

A breached this restraining order and subsequently was detained in custody and later placed in a hospital under Section 37 of the Mental Health Act with a restraining order as there were concerns about public safety and levels of risk
A safeguarding adult referral was raised and a multi-disciplinary meeting was held within the MARAC forum. Here protective actions were undertaken to safeguard the client both in the long and short term.

These included:

- Ongoing support from her Independent Domestic Violence Advocate from the NIA project (a service that supports women assessed as being at high risk from domestic violence).
- Input from the Police via use of special measures, involving increasing security measures at the client's home.
- Liaison with mental health services to ensure that there was a high level of communication across services, with all putting Mrs W's wellbeing at the centre of work undertaken.
- Ongoing liaison with Housing across boroughs and within voluntary and statutory sectors to ensure that Mrs W. was prioritised for reallocation of tenancy.

Mrs W self-defined rehousing as her main priority. She advised that she was fearful of returning to her home and had been spending her time with her daughter in another local authority.

This multi-disciplinary approach resulted in a third local authority agreeing to a reciprocal arrangement with Mrs W's Housing Association in Hackney Communication with Mrs. W re any ongoing plans in connection to her grandson was also arranged-ensuring that she was informed of any discharge planning and fully involved in accessing specialist advice and support from both safeguarding and domestic abuse services.

4 Developments against the 2013-14 priorities

The overarching aim of the CHSAB is to achieve positive outcomes for adults at risk and their carers through prevention and intervention. All of the Board's priorities contribute to both the prevention of abuse and neglect and to effective intervention where allegations of abuse and neglect are made. The critical areas for development for the Safeguarding Adults system in Hackney over the last year were:

- To further improve our processes to identify and address substandard health and social care services;

- To build on our work to understand better the views and wishes of our service users and carers to improve practice and inform service development.

- To cement strategic arrangements with the new Health and Wellbeing Board and local Clinical Commissioning Group.

As well as maintaining core operational effectiveness, the CHSAB agreed to continue to address five core areas on which it focussed its work over the year 2013-2014:

- Public awareness raising
- Developing performance management and quality assurance across agencies working with adults-at-risk in the City and Hackney
- Personalising adult safeguarding
- Involving service users
- Getting the Governance arrangements right.

4.1 Public awareness raising

- We have continued our work to raise awareness of adult safeguarding amongst members of the public and professionals. Yearly planned events have included, for example, the Big Do (for people with Learning Difficulties), Older Persons Reference Group, and World Mental Health Day as events for service users, carers and professionals.

- Our safeguarding publicity material has been reviewed with leaflets and pamphlets being widely available for the public.

- During 2013-14 there were **4,027** hits on the Safeguarding Adults section of the Hackney council website. Although this is significantly fewer than last year (**7,541**) it is very close to the number of hits on the child protection page for 2013-2014 (**4,189).** These figures will be kept under review in the year ahead

- In 2013/14 Hackney Council provided 24 training events free of charge which were attended by 487 individuals or organisations working with or representing adults at risk and their carers. 340 people attended from service provider organisations and 147 from the council.

- 64 GPs attended two safeguarding sessions and 20 Metropolitan Police staff attended an event to support their training needs.

- We will help run more partnership training events for Hackney GPs and health professionals in 2014-15.

- Our ongoing work to raise awareness within the community about abuse and neglect of adults at risk aims to reduce the number of adults whose suffering may go unreported. In 2014/15 we plan to have Safeguarding Awareness campaigns in both the City of London and Hackney.

4.2 Developing performance management and quality assurance across agencies working with adults-at-risk in the City and Hackney

- We continue to seek improvements in the quality and integration of intelligence about standards of care, and in the robustness of responses to poor quality. The Council has reviewed all its placements for service users with learning disabilities to meet its obligations under the Post-Winterbourne Improvement Plan. There is also a new internal protocol for rapid responses to concerns about providers. This is to ensure co-ordinated and proportionate action is taken by officers within the Safeguarding Adults Team, Adult Social Care and Learning Disability services, and Contracts and Commissioning teams.

- This year we reviewed 25 care homes to check on the quality of care provided. 14 were scheduled visits and 11 were in response to concerns. Reports on these providers were made to our Quality Assurance and Safeguarding Board to review progress and consider recommendations for service improvement.

- Of the 11 providers where there were concerns, 7 were outside Hackney. Joint monitoring visits took place with the Contract Monitoring and Safeguarding teams of 6 other local authorities. Action plans were put in place by the host authorities but were monitored by the Contract Monitoring team in Hackney to ensure that residents were safe and to maintain focus on improvement of standards at the homes.

- In our work with partners to strengthen safeguarding processes across the borough, we developed a joint protocol with local mental health services to

make certain their responses to safeguarding concerns are proportionate. We advised Homerton University Hospital NHS Foundation Trust on safeguarding cases and application of the Mental Capacity Act.

- Hackney Council commissioned an independent review of its safeguarding practice between October and December 2013. There were positive findings around the strategic development of the Board and around many aspects of safeguarding practice. Areas which were found to require improvement, included more consideration of the views of the adult at risk, and clearer and more detailed case recording.

  The recommendations of the review were as follows:

  - Clear recording of risk assessment and analysis which has been discussed with the adult at risk wherever possible;
  - Clear recording of the adult at risk's views, wishes and desired outcomes;
  - More consideration of carers' needs and how they can be supported;
  - Advocacy support for adults at risk to be considered more frequently;
  - Clear evidence of follow-up of protection plans by managers;

  In response to the review an improvement plan was undertaken that sought to support further positive service development, and strengthen areas of practice, locating our citizen's health and well-being at the forefront of our interventions.

- Over the last year the Board has strengthened relationships with other strategic bodies. The City and Hackney Safeguarding Adults Board has formal links with:

  - The Community Safety Partnership
  - The Safeguarding Children's Board at strategic and operational levels. The Corporate Director for Health and Community Services is a member of the Safeguarding Children's Board. A senior practitioner from the Safeguarding Adults team now attends the operational forum of the Safeguarding Children's Board.
  - Health and Well Being Boards
  - The Multi Agency Public Protection Panel (MAPPA) (part of the Crime Reduction Partnership System organised through Police and Probation).
  - The Multi- Agency Risk Assessment Conference (MARAC)
  - Care Quality Commission (CQC)

  At an operational level the Safeguarding Adults team has also worked with partner agencies to support the following:

- Co-ordination of strategic work to address domestic violence in Hackney.
- Overarching quality assurance of adult safeguarding arrangements at NHS organisations in the City and Hackney.

- City & Hackney Clinical Commissioning Group (CCG)
- East London NHS Foundation Trust
- Homerton University Hospital

- Quality assurance of adult safeguarding arrangements with Met. Police
- Quality assurance of adult safeguarding arrangements with London Fire Brigade

4.3 Personalisation

- Personalisation is about enabling people to lead the lives that they choose and achieve the outcomes that they want in ways that best suit them. A person-centred approach was embedded in our training programme in line with the person centred model of safeguarding described in the London multi-agency procedures.

- The London multi-agency policy and procedures to safeguard adults from abuse provide a framework that places the views and wishes of adults at risk at the centre of safeguarding work. Over the last year we have ensured professional supervision, by application of standardised agenda.

- Our staff have measured performance in terms of outcomes, rather than outputs of safeguarding work. We have participated in, and learned from, national work to develop best practice in adult safeguarding. This is described in our work involving service users (see section 4.4 below).

- An interview schedule has been developed to capture service users' views of the safeguarding process and staff are expected to use this where appropriate. In addition, the Council is contributing to a national pilot study to develop a safeguarding outcomes measure. The research project started in May 2014 and is led by the Health & Social Care Information Centre (HSCIC) and the Social Care Workforce Research Unit at Kings College, London. To demonstrate how we are making social care more personalised and focused on the best outcomes for the people we help, we will carry out 20 face to face interviews and undertake a project with service users to hear their views on standards for safeguarding.

Development of a person-centred approach to safeguarding continues to be a priority as the local authorities need to comply with the Care Act and fulfil their commitments to Making Safeguarding Personal.

Case example Mrs S: Making safeguarding personal

Mrs S is an 83 year old woman who lives in a residential care home in Hackney. Mrs S needed help to wash, eat, drink, use the toilet and take her medication. Her daughter raised a safeguarding alert because she felt nursing staff were neglecting her mother. Although Mrs S was placed in the home by another health authority, it was Hackney Council's responsibility to investigate her daughter's concerns. We assigned Mrs S a social worker and held a meeting where we put together a robust protection plan. Mrs S was allocated her own worker who sat with her during mealtimes to make sure she ate and drank. We also asked the home to provide evidence that this was happening. Her GP agreed to keep a close eye on Mrs S and support any plans to help with her nutrition. The nursing home created a social stimulation plan to try to improve Mrs S's mood and desire to eat and drink. We also supported the nursing home to improve the way they communicated with the family. We contacted the daughter some time later who told us she felt her mum was safer now and that she had felt properly listened to and consulted through the safeguarding process.

4.4 Involving Service Users

- Building on a pilot project which was undertaken in 2012 /13, we have taken the feedback given and incorporated this into our operational practice to ensure outcomes for service users are discussed as quickly as possible.

- We held an event with local mental health service users to improve communication with service users and their awareness of safeguarding in partnership with local police.

- We met our target of interviewing service users post safeguarding to find how well it worked for them. Service users provided feedback that they were happy with the speed of the safeguarding intervention and the way their safety was protected. We plan to build on this by taking part in a national pilot which endorses standards for us to meet in meeting the personal needs of our service users.

- The independent review has challenged the Board to review models of engagement. The Board continued to improve systems for gaining service user input at a strategic level. We have:

    - Taken account of the views of service users and their carers and see them as key partners in safeguarding strategic planning. As a result of the small pilot project and service user involvement events such as Working Together Group (mental health service user forum) we have introduced service users being interviewed following a safeguarding intervention and we are working towards specific user-led standards for adults at risk procedures.

    - Developed the role of CHSAB members with user and carer groups so that they can feed in any issues pertaining to adult safeguarding to their discussions and to ensure that the views of these groups are heard at the CHSAB.

- We plan to form a Task and Finish Group to underpin a review of models of service user involvement within the Board's governance framework.

- With wide-reaching changes to health and social care systems in the UK taking place at present, it will be vitally important to ensure that arrangements for the governance of adult safeguarding work in the City and Hackney are flexible and robust. An away day of the Board in early 2013 began this work and we continue to review these arrangements during 2014. (see also 4.5)

We have:

- developed the relationship between the City & Hackney Clinical Commissioning Group and CHSAB and ensure that matters of adult safeguarding have a high profile. An identified adults at risk lead is in post at the CCG to strengthen and develop strategy for safeguarding adults.
- developed the relationship between children's and adults' services at Hackney council and the City of London to ensure that work with vulnerable families is of a high quality. A programme of training is already in place which is supplemented by local shadowing arrangements, where staff join colleagues to familiarise themselves with practice. These arrangements support continuous professional development and improve communication and understanding of each other's roles;
- developed the relationship with the Health and Wellbeing Boards in the two authorities in order to be influential

4.5 Getting the governance arrangements right

- The Board recognised that a review of its governance and constitution was needed, both to meet the planned requirements of the new legislation placing safeguarding adults on a statutory footing, as well as to maintain high quality services.

- The review of CHSAB constitution was led by the Independent Chair and agreed the need for new governance arrangements supporting the Board. The review noted the benefit of aligning governance arrangements with the Children's Safeguarding Board which has been a long-standing statutory function and develop a more symmetrical model of governance for children's and adults' arrangements.

- The governance model is set out in appendix 1.2. There will be sub-groups for Quality Assurance, Serious Case Review, Training and Development, City Of London, and Communication and Engagement. The core business of these groups will be: prevention, linking up lessons learned from incidents with our training programme, increasing public awareness, promoting the health and wellbeing of our residents, with the overall aim of increasing independence and ensuring that proportionate action is taken to safeguard our vulnerable residents.

- In addition an Executive Board has been created which includes senior managers of key agencies to oversee the Board's strategy. We anticipate the Executive Board will improve communication and strengthen partner

accountability. Members of the Executive Board will chair the sub groups and provide performance reports to the Executive Board.

- We have undertaken a self–assessment audit of the Board utilising the NHS England audit tool. The outcomes of this assessment will be used by the Board to identify improvement needs and prioritise its work for 2014-2015.

5 Safeguarding Data and Analysis for the City of London and Hackney

City of London

5.1 City of London Adult Social Care Team

- With a small reablement team of 2 officers and an occupational therapist, the social work team establishment is 4 FTE's and one part time substance misuse worker. Two of the social workers are Approved Mental Health Practitioners. All social workers hold fully generic caseloads which average up to 25 cases, and are expected to undertake a full part in the daily duty rota as well as for the AMHPs, run a mental health duty service and work with the Hackney AMHPS once per month as part of their duty rota.

5.2 City of London Safeguarding Alerts and Referrals

- Adult Social Care (ASC) currently knows of 250 people referred and living in the community, both in the City and placed outside.

- All alerts and referrals of safeguarding are managed through the Adult Social Care team. An alert may be a result of a disclosure, an incident, or other signs or indicators. A referral is when an alert (following a decision made by the Team Manager) is accepted to be a safeguarding issue and is managed through the safeguarding process. Adult Safeguarding is an integral part of the whole team approach, with two social workers being trained as Safeguarding Adult's Managers (SAM's) as well as the Team Manager. There is a designated social worker who carries out care home reviews as a direct response to the Winterbourne review.

5.3 City of London Analysis of Adult Safeguarding

- The number of Safeguarding Alerts received from April 2013 to March 2014 was 28. 14 were within the City of London and 14 were outside the City in placements. There has been an increase in alerts raised this year, in

comparison there were 20 alerts raised in 2012-2013, with 6 alerts regarding residents placed outside the City.

- People placed by the ASC team outside the City and who are subject to safeguarding, are not counted for DH reporting purposes by the placing authority as they take the lead when a safeguarding action takes place within their local authority.

- Of the 14 City of London alerts, 7 were progressed to referral with a strategy meeting and protection plan. The 7 other alerts were diverted from the formal safeguarding process but support and care was provided in all cases.

- Of the 7 cases progressed to referral, 3 were substantiated, 1 was partially substantiated, 1 was unsubstantiated, 1 investigation was ceased at the service user's request, and investigation 1 remained on-going at the time of this report's completion.

- The 7 cases are categorised as follows:

  Types of abuse.
  - 2 psychological / emotional
  - 1 financial
  - 4 neglect and acts of omission

  Gender
  - 3 men
  - 4 women

  Ethnicity
  - 7 white UK

  Person alleged to have caused harm (PACH)
  - 4 were known to service user
  - 3 were unknown to the service user

  Service user group
  - 6 physical disabilities
  - 1 mental health (Dementia)

  Within the City of London, alerts have been raised concerning informal carers, privately arranged care, one hospital discharge and people not known to the service users. One case involved a commissioned provider.

London Borough of Hackney

5.4 Role of Hackney Safeguarding Adults Team

The Safeguarding Adults Team acts as the single point of entry for all safeguarding concerns. The Team determines whether the adult at risk is known to social services or health services and asks the appropriate department to investigate. Each investigation is led by a trained Safeguarding Adults Manager (SAM).

The SAM identifies all those who can help to protect the adult at risk or help with the investigation. These may be family members, service providers, health professionals, the police or Hackney Client Financial Affairs Team.

An initial risk assessment is completed to determine what response is needed. If further action is required then a strategy meeting will take place chaired by the SAM. This will confirm the protection plan for the adult at risk and identify who will carry out the investigation. Further meetings will be arranged to confirm the outcome of the investigation and to review the protection plan. The person and their carer/family will be supported to be involved as much as possible.

Sometimes the person causing harm is also an adult at risk of abuse. In such cases the safeguarding process will consider whether they need their own protection plan to help them avoid facing any allegations in the future.

The desired outcome from review of our post safeguarding interviews is to feel safer and have a better quality of life. If the person cannot make their own decisions about their care then they may need to be protected in their best interests.

Types of protection include:

- Increased monitoring –e.g. more frequent reviews, more contacts with staff
- Enabling the adult at risk to stay away from the person causing harm
- Better management of the finances of the adult at risk
- Application to the Court of Protection (a court that makes decisions based on best interests where there are disputes over serious decisions regarding a person's welfare)

Whenever possible the person causing harm should be held to account. This can be done through criminal and /or civil law, or by the employer.

5.5 Safeguarding Adults Activity in Hackney 2013-2014

- During 2013-14 LBH Hackney received 713 safeguarding alerts, 41 (6%) more than in 2012-13. This is an average of 59 alerts a month. The increase can be attributed to a number of factors including: more people being aware of possible harm are willing to report it; communications and training programmes to raise awareness of safeguarding issues having more impact.

- A safeguarding alert is triggered when a contact is made suspecting abuse may be occurring. Not all alerts lead to a formal safeguarding investigation. Last year Hackney Safeguarding Team formally investigated 37.6% (268) of the 713 new alerts received. The remainder were reviewed and did not warrant a formal investigation.

- Some adults at risk will have more than one safeguarding alert raised in a year. The 713 safeguarding alerts were received for 601 people. 511 adults at risk had only one alert raised in 2013/14. **112 (16 %)** of the year's alerts were on behalf of 90 adults at risk who had already had an alert raised in the year.

		Number of Adults at risk we received an alert for 2013/14	Additional Alerts following the first per adult at risk	Total Alerts 2013/14
Total number of Alerts for the Adult at risk during 2013/14	One alert	511	0	511
	Two alerts	73	73	146
	Three alerts	13	26	39
	Four alerts	3	9	12
	Five alerts	1	4	5
		601	112	713

- It is likely that the multiple alerts were reporting the same incidents of abuse and this is a good indication of the wide range of agencies that have knowledge of the local safeguarding procedures.

- Of the 112 *repeat* alerts, 32 (29%) went on to receive a safeguarding investigation, and of these 32 investigations there were 14 cases where abuse was substantiated or partially substantiated.

- Financial abuse is the most common type of abuse, though cases of neglect are on the increase in Hackney. Most incidents (104) took place in the person's own home while 24 happened in care homes.

The graph below shows how the number of safeguarding alerts has continued to rise in recent years.

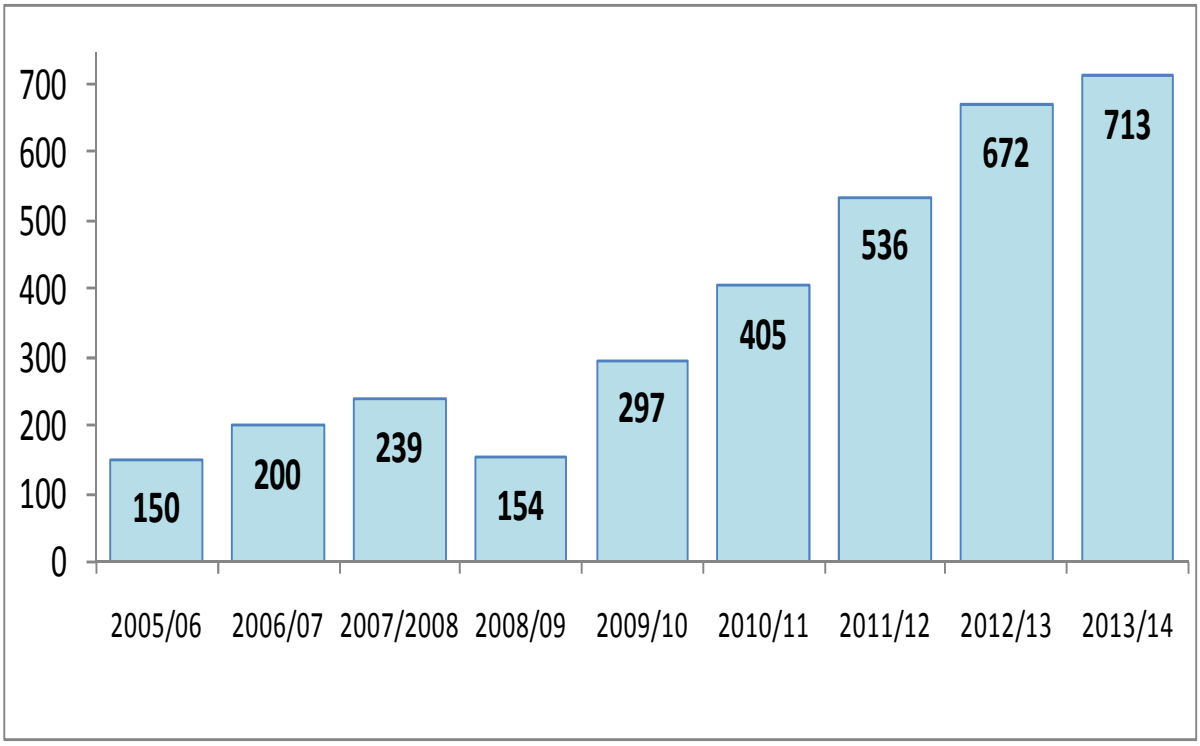
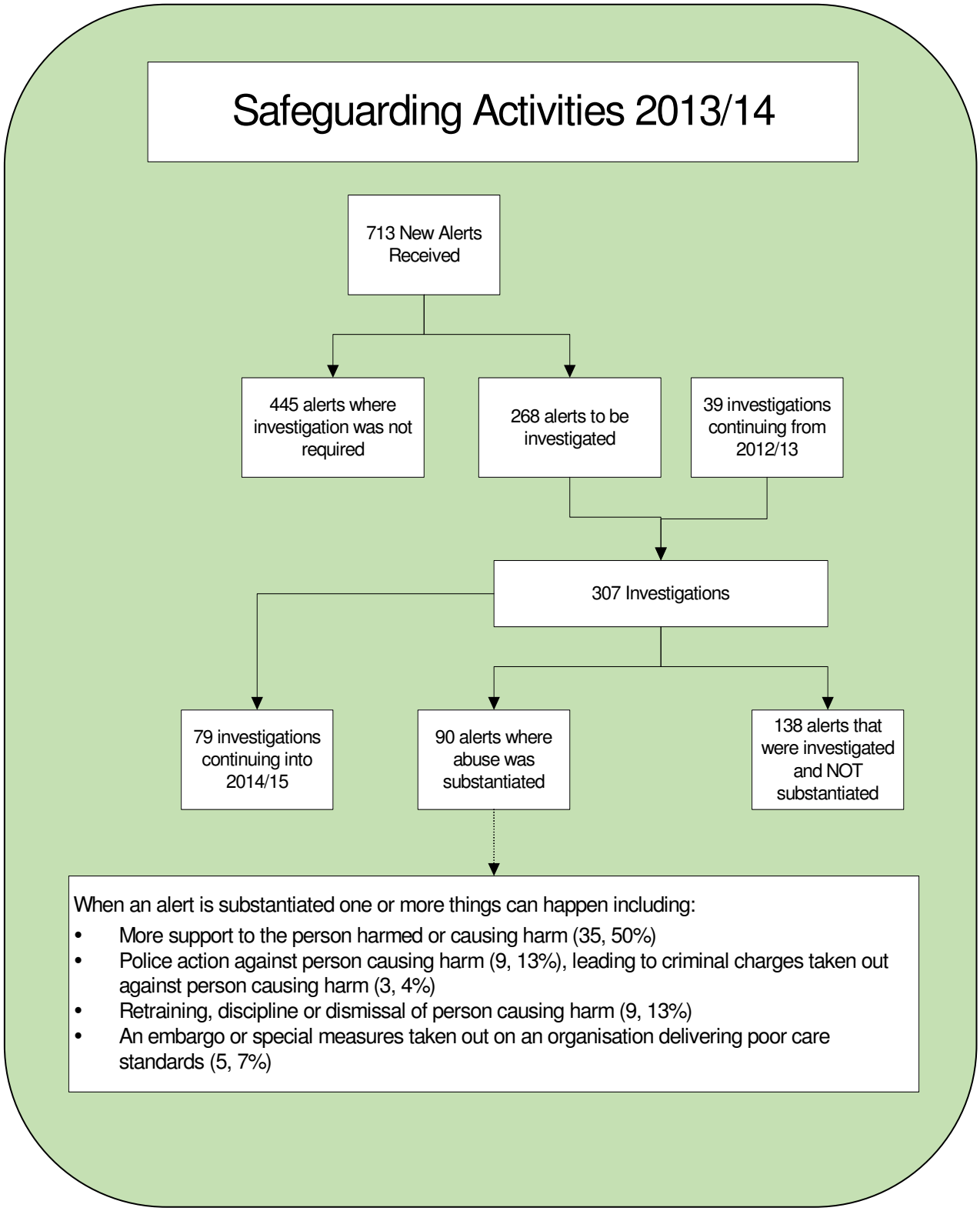


Figure 1: No of safeguarding alerts per year

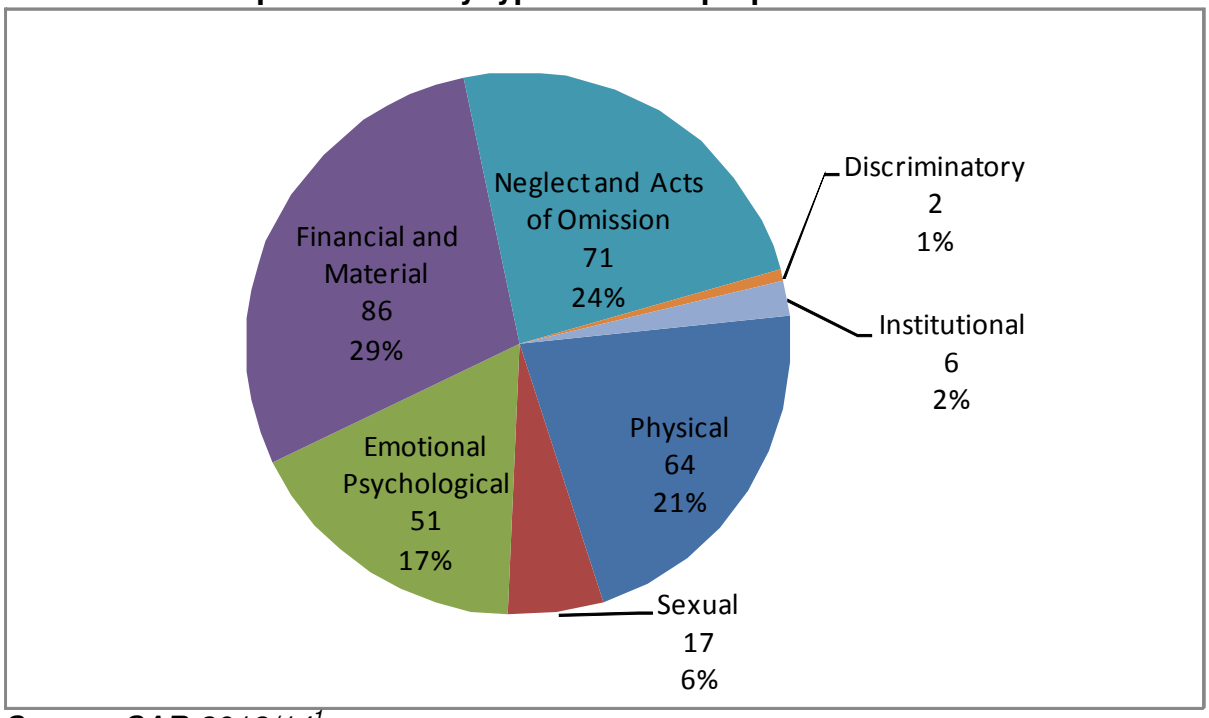
The diagram below shows how we responded to the alerts we received.



Types of abuse

- Financial abuse remains the most prevalent type of abuse in Hackney interventions (29%), but there has been a reduction in prevalence since last year. 2013/14 has seen an increase in abuse by Neglect and Acts of Omission (from 18% last year to 24% in 2013/14).

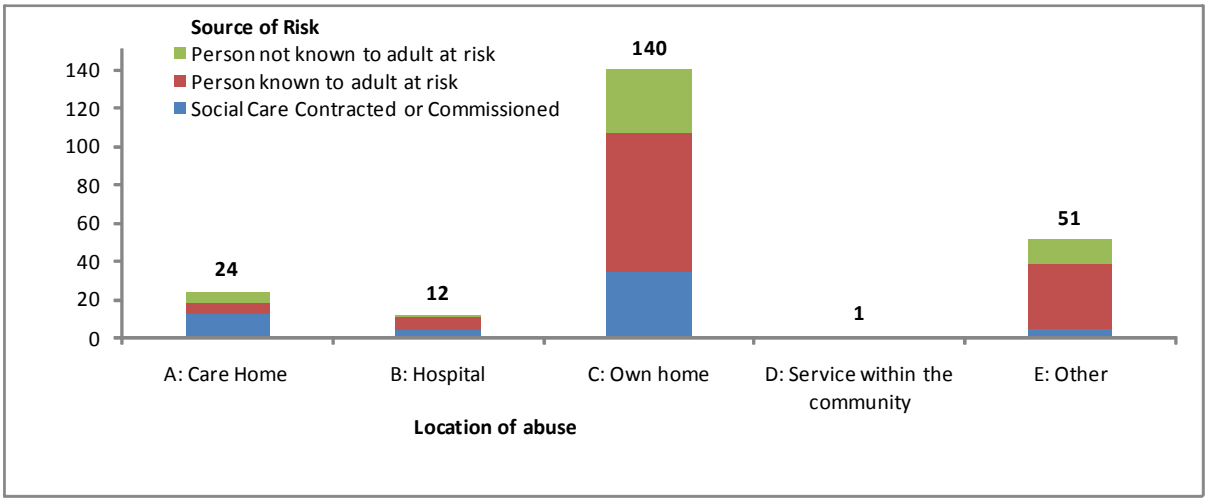
Figure 2: Alerts accepted for investigation and action under safeguarding adults procedures by type of abuse perpetrated.



Source: SAR 2013/14[1].
NB: There can be more than one type of abuse identified for a single case, 68 cases investigated in 2013/14 had multiple types of abuse investigated.

[1] The Safeguarding Adults Return (SAR) is an annual statutory data return for Local Authorities. The SAR addresses various aspects of safeguarding, with particular regard to the details of the victim, the alleged perpetrator and the alleged offence. It strengthens the information held nationally and locally on the incidence of abuse, supporting local authorities to reduce incidents of abuse and neglect, and to respond appropriately when incidents occur.

Figure 3: Completed safeguarding investigations by location of abuse and source of risk for the vulnerable adult



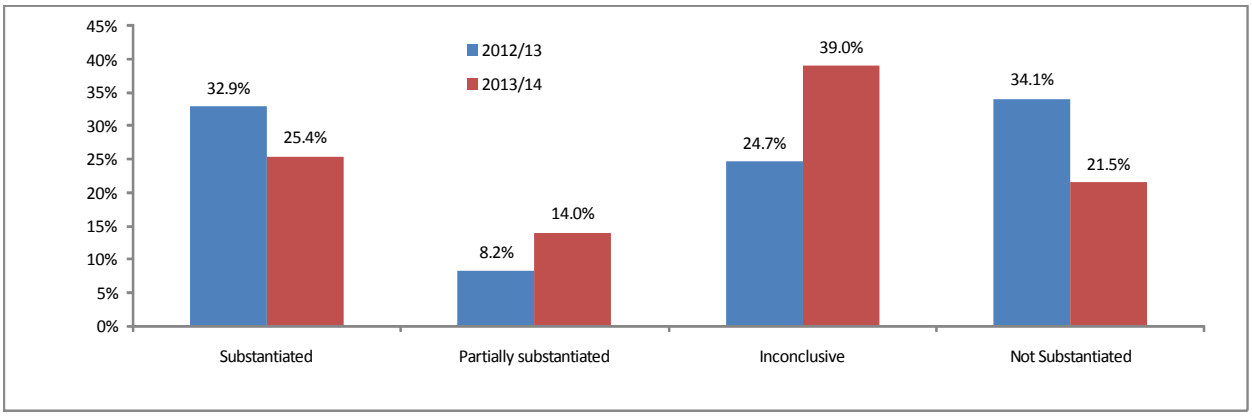
- The high percentage of abuse of vulnerable adults by people they know is confirmed again this year in our analysis of the 228 completed safeguarding cases. 52% of investigations found the source of risk to be known to the adult at risk. 61% of investigations also found that the location of abuse was the victim's own home. The prevalence of domestic abuse by family members is consistent with previous analysis.

	Source of Risk			
Location of abuse	Social Care Contracted or Commissioned	Person known to adult at risk	Person not known to adult at risk	Total
A: Care Home	13	5	6	24
B: Hospital	4	7	1	12
C: Own home	34	73	33	140
D: Service within the community	1			1
E: Other	5	34	12	51
Total	57	119	52	228

Source: SAR 2013/14

Investigation Outcomes

Figure 4: Outcomes of completed safeguarding investigations, 2012/13 and 2013/14.

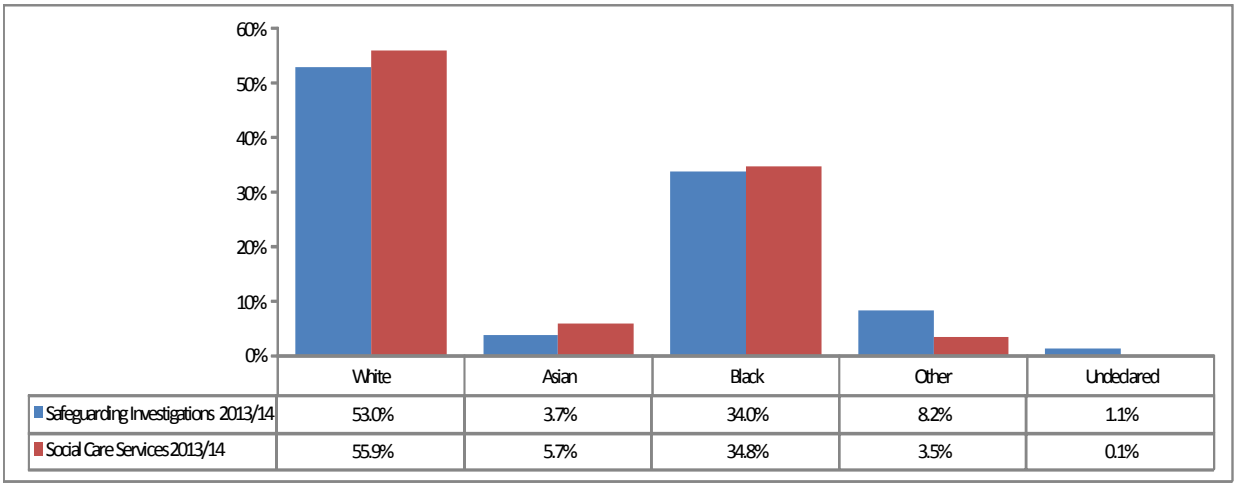


Source: SAR 2013/14

Compared to last year there has been a drop in cases where the abuse was substantiated following safeguarding investigations, but an increase where it has been partially substantiated. This may indicate more thorough recording of outcomes and more comprehensive investigations. There are more cases where the outcome is inconclusive rather than not substantiated compared to last year, which may also indicate more complex investigations. These variations, while notable, are not cause for concern and there is a close correlation between the two years of data.

Ethnicity of adults-at-risk

Figure 5: Comparison of the ethnic profile of accepted safeguarding cases with the ethnic profile of Service Users receiving Adult Social Care Services 2013/14.



	White	Asian	Black	Other	Undeclared
Safeguarding Investigations 2013/14	53.0%	3.7%	34.0%	8.2%	1.1%
Social Care Services 2013/14	55.9%	5.7%	34.8%	3.5%	0.1%

Source: SAR 2013/14.

- There is a strong correlation between the ethnic profile of alerts for adults at risk and the profile of our care population for several years. Further analysis will be required for Hackney as the Department of Health ethnicity requirements for the SAR are minimal and do not account for the ethnic diversity in the borough.

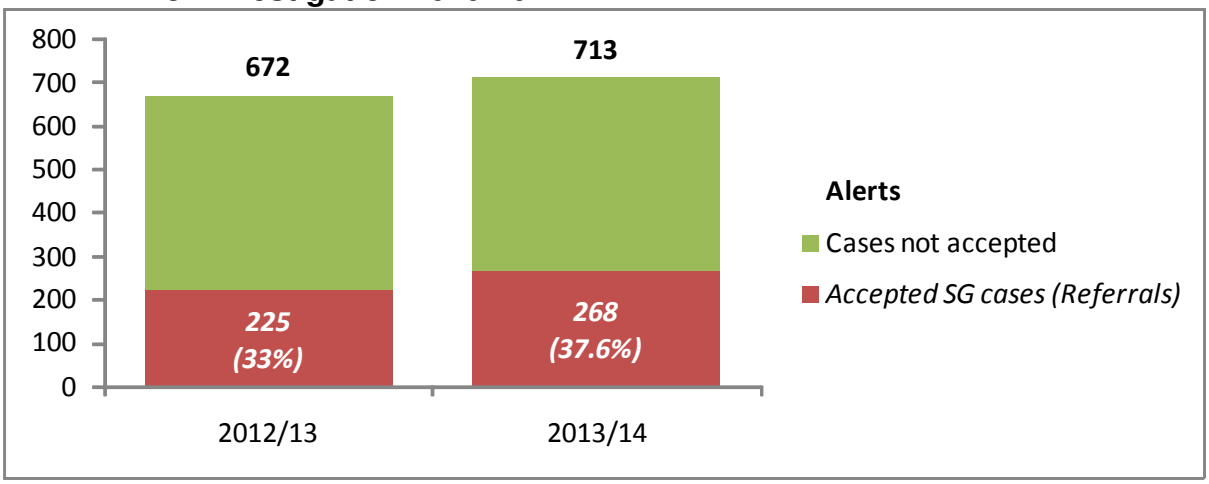
Gender of adults at risk

- Females have a slightly higher proportion of safeguarding alerts at 51%. This is a consistent pattern.

Proportion of safeguarding alerts that required investigation and action under safeguarding adults policies and procedures

- The proportion of alerts that became accepted safeguarding cases has slightly increased since last year from 33% to 37.6%.

Figure 6: Analysis of Safeguarding alerts and proportion of cases accepted for investigation 2010-2014

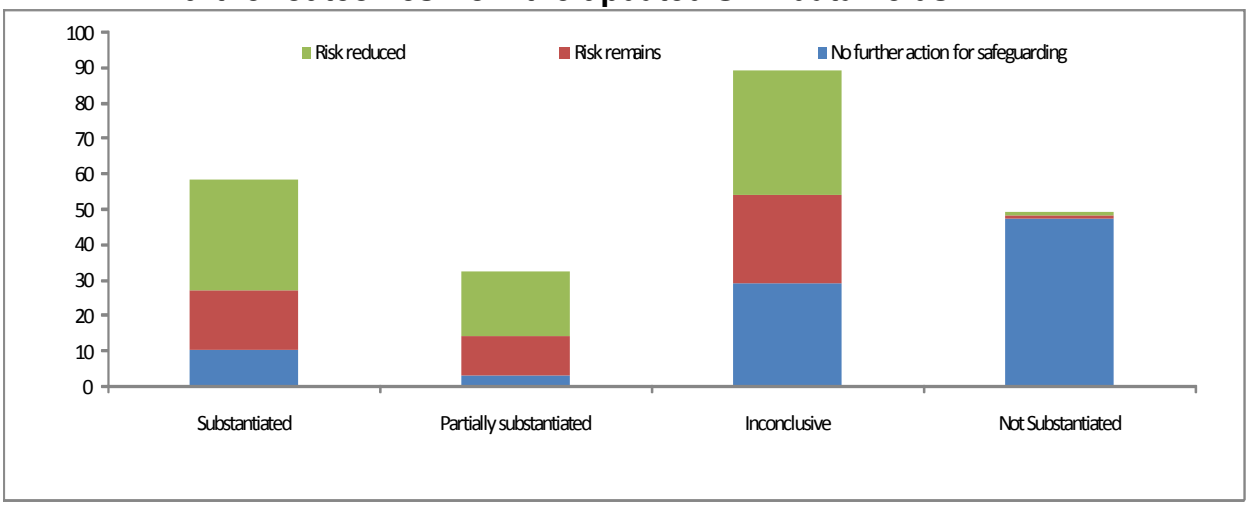


Source: SAR 2013/14

Actions taken to safeguard adults-at-risk

- The SAR was amended for 2013/14. Further analysis is possible but should not affect the outturns for the statutory return. The following analysis can now be made from the amended SAR collection.

Figure 7: Outcomes of completed safeguarding investigations 2013/14 with further outcomes from the updated SAR data fields.



Source: SAR 2013/14

- We do not record any outcomes with the SAR outcome "Risk Removed", as it is not possible to remove risk completely. However no further action for safeguarding is shown here, usually when cases are passed back to care management in LBH.

Safeguarding alerts by client group for the last three years

- The number of alerts from adults at risk with substance misuse issues has dropped down to the levels recorded for 2011/12. The number of adults at risk with learning disabilities has increased 20%. Alerts from older people with mental health problems have increased 65%, but this is most likely due to improved recording of mental health issues for older people at risk.

Figure 8: Safeguarding alerts 2011-2014 by client group and age.

Age Range	Service User Category	Alerts 2011/12	Alerts 2012/13	Alerts 2013/14	% difference 2012/13 to 2013/14
18 - 64	Physical Disabilities	92	124	121	-2%
	Mental Health	102	132	141	7%
	Learning Disabilities	85	84	106	26%
	Substance Misuse	18	48	12	-75%
18-64 Total		297	388	380	-2%
65 +	Older People	176	222	226	2%
	Older People with Mental Health Problems	63	62	107	73%
65 + Total		239	284	333	17%
Total		536	672	713	6%

Source: SAR 2013/1

5.6 Deprivation of Liberties Safeguards Activity Data 2013-2014

- Caring for people with complex needs and cognitive impairment sometimes requires restriction of their freedom in their best interests. A high level of restriction can amount to a deprivation of their liberty under Article 5 of the European Convention on Human Rights. Such a deprivation can only take place if it is properly authorised in accordance with the 2009 amendments to the Mental Capacity Act.

  The Safeguarding Adults team is Hackney's "supervisory body", responsible for giving authorisations for deprivation of liberty when the relevant criteria are met. Applications may be made by care homes or hospitals, or family members and friends may contact the supervisory body to express concerns over possible deprivation of liberty.

  The supervisory body aims to promote a human rights based and person-centred approach while ensuring that service users are not exposed to unacceptable risks. The team also appoints Independent Mental Capacity Advocates (IMCAs) to support people through the assessment process and sometimes when the authorisation is in place, if they do not have any family or friends who can take on this role.

- In 2013 - 2014 there were 23 applications for DoLS authorisations of which 13 were approved.

- As discussed earlier, in March 2014, the Supreme Court reviewed the definition of deprivation of liberty to make it more inclusive, which is leading to a substantial increase in Dols activity. In the period April – October 2014 173 applications have already been received and around 300 are expected in total. This has led to increased demand for best interests assessors (BIAs), training for care management and service providers, and increased pressure on administrative services.

- The DoLS team in Hackney is keeping the situation under review to identify innovative ways of using resources more effectively. This will be discussed in full in next year's report.

5.7 Developments for 2014/15

The table below sets out what LBH Hackney did to protect adults in 2013-14 and what we plan to do in 2014-15.

What we said we would do	Examples of what we did and what we plan to do
Monitor care homes to make sure they improve care and communication with residents and families	In 2013-14 we: • Carried out 24 investigations into safeguarding concerns in care homes • Checked 25 care homes to see how well they listened to residents and relatives and met clients' needs. In 2014-15 we: • Will make sure that we monitor every care home in Hackney in which Hackney residents are placed ; • Will gain intelligence on homes within Hackney where no Hackney residents are currently placed and liaise with CQC regarding any concerns; • Will also work with other local authorities where Hackney service users live.
Make sure home care agencies continue to receive safeguarding awareness training and monitor home care	In 2013-14: • 487 staff from Hackney Council and service providers attended our safeguarding training programme at 24 training events • We closely monitored six home care agencies in Hackney where there were concerns over standards of care. We worked with the organisations and CQC to improve the quality of care. In 2014-15 we will: • Publish a safeguarding awareness pack for people who pay for their home care with a direct payment. The pack will also be useful for people who fund their own care.
Interview 10 people (3%) who undergo safeguarding to find out how well it worked for them	In 2013-14 we: • Identified 10 people to interview, five declined, one was too unwell to take part. Four people who agreed to be interviewed said they were happy with the speed of the safeguarding intervention and the steps taken to protect their safety In 2014-15 we: • Will take part in a Department of Health pilot study on how we are making social care more personalised. • Will carry out 20 face to face interview with adults at risk in 2014

Arrange enhanced training for staff who undertake safeguarding investigations	In 2013-14 we: • Developed a training programme for staff that included legal training for lead safeguarding investigators In 2014-15 we: • Will run more training events to help staff to listen better to clients' views and wishes during investigations
Extend safeguarding training to GPs, practice nurses and emergency services	In 2013-14: • 64 GPs and practice nurses attended safeguarding training sessions • 20 police staff attended specifically tailored training In 2014-15: • We will run more training events for Hackney GPs and health professionals.
Make sure the views and wishes of people with support and their families are properly taken into account	In 2013-14: • An independent review of our safeguarding service gave positive feedback on a number of areas of practice. • The review also recommended we strengthen our person centred approach to adults at risk. We will work on this during 2014-15. In 2014-15: • We will develop quality standards which take into account the views of people who have undergone safeguarding, their families and their carers
Work with partners to strengthen safeguarding processes across the borough	In 2013-14 we: • Advised Homerton University Hospital on safeguarding cases and how to apply the Mental Capacity Act (MCA) when people without capacity need medical treatment or surgery for serious conditions • Reviewed 700 MERLIN reports on vulnerable adults who had come to the attention of the local police to make sure they got the most appropriate help • Launched a quarterly Safeguarding Adults Newsletter to provide updates on good practice, case law, and training opportunities In 2014-15 we: • Continue to work closely with partners to ensure our processes are robust
Raise public awareness of so people in the wider	In 2013-14 we: • Reviewed our publicity material and made it widely available to the public

community know how to recognise and report abuse	• Promoted safeguarding awareness at local events including • Hackney Carnival • World Mental Health Day Partnership • Working Together Group – for mental health service users • An information sharing event with local advocacy services In 2014-15 we will: • Run a safeguarding awareness campaign to continue to help diverse communities in Hackney to understand how safeguarding adults can support them.

6 Priorities of the CHSAB 2014/2015

The critical areas for development for the Safeguarding Adults system in Hackney over the coming year include:

- Improving further our processes to identify and address poor quality health and social care services.
- Building on our work to understand better the views and wishes of our service users to inform service development.
- Embedding our improvement plan to implement the recommendations of the independent review undertaken in 2013.
- Cementing strategic arrangements with the Health and Wellbeing Boards City & Hackney Clinical Commissioning Group and Community Safety Partnerships
- Developing the identified sub groups of CHSAB governance framework for CHSAB
- Continuing our preparations for implementation of the Care Act.

7 Key Contacts

Everyone has the right to live free from abuse and neglect. If someone is harming you, or you suspect someone is at risk of harm, you can tell the police, a social worker, a nurse or someone you trust.

For Hackney:
You can contact Hackney Council's safeguarding adults team directly on:

Tel: **020 8356 5782** Outside office hours tel: **020 8356 2300**

Email: **adultprotection@hackney.gov.uk**

or visit our Safeguarding Adults pages on the council website
http://www.hackney.gov.uk/safeguarding-vulnerable-adults.htm#who
.

For City of London:
You can contact the City of London's Adult Social Care Team directly on:

Tel: 0207 332 1224 Outside office hours Tel: 020 8356 2300

Email: social.services@cityoflondon.gov.uk

or visit our Safeguarding Adults pages on the website
http://www.cityoflondon.gov.uk/services/adult-social-care/Pages/safeguarding-adults.aspx

Useful web links

Pan-London policy on safeguarding adults from abuse:
http://www.hackney.gov.uk/Assets/Documents/scie-report-2011.pdf

Action on Elder Abuse:
http://www.elderabuse.org.uk/

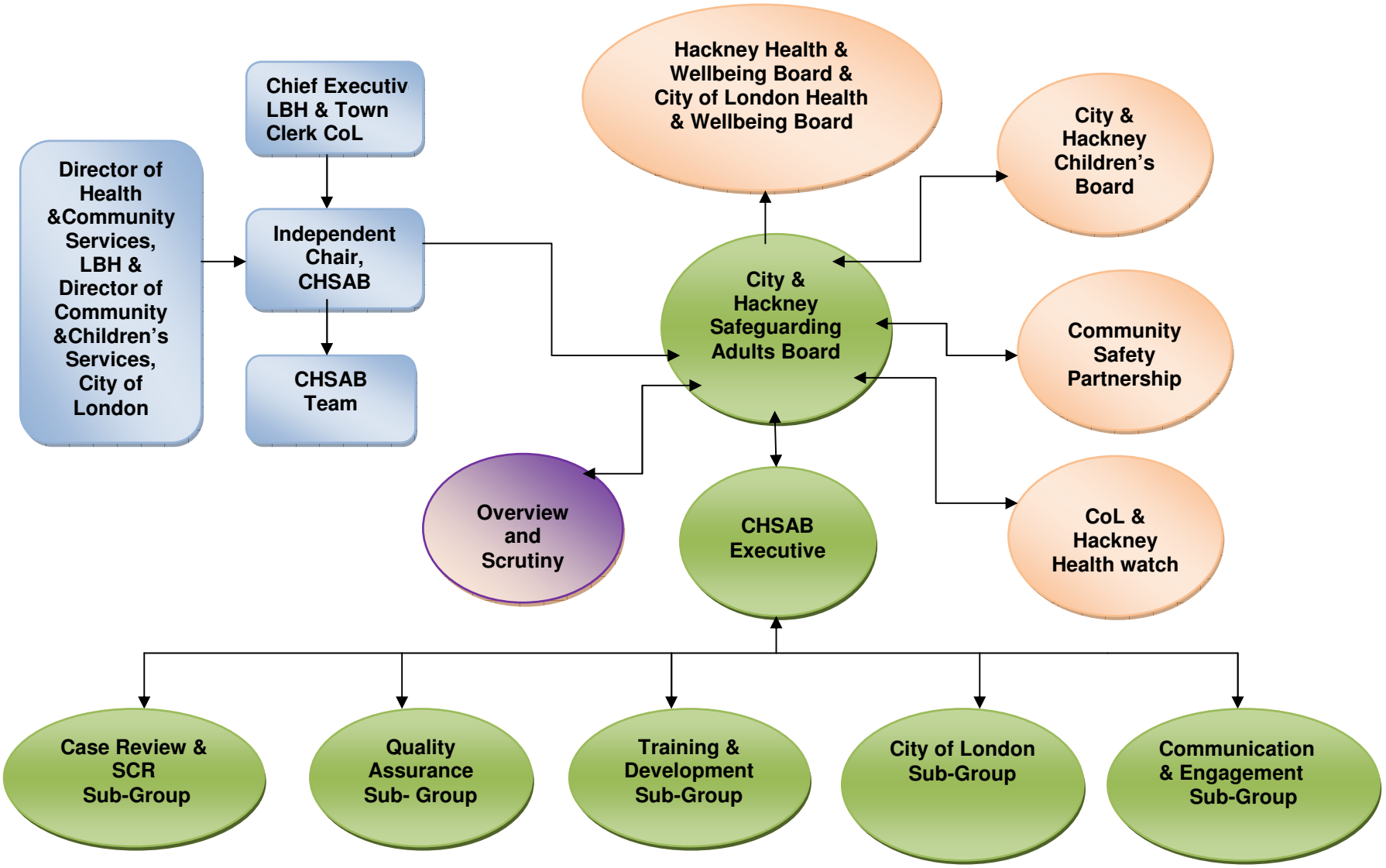
Appendix 1: Safeguarding arrangements in the City & Hackney

1.1 Membership City and Hackney Safeguarding Adults Board 2013-14

	Agency	Role
1.	City and Hackney Safeguarding Adults Board	Independent Chair
2.	London Borough of Hackney	Lead Member
3.	City of London	Lead Member
4.	London Borough of Hackney	Corporate Director of Health and Community Services
5.	City of London	Deputy Director of Adult and Community Services
6.	London Fire Brigade, Hackney	Borough Commander
7.	Homerton NHS Foundation	Chief Nurse & Director of Governance
8.	Homerton NHS Foundation	Head of Adult Safeguarding
9.	East London Foundation Trust	Deputy Borough Director
10.	East London Foundation Trust	Associate Director Safeguarding Adults and Domestic Abuse
11.	City & Hackney Clinical Commissioning Group	Adult Safeguarding Lead
12.	Hackney Council for Voluntary Services	Chair of Hackney Carers Centre
13.	City of London	Head of Community Services
14.	Older People's Reference Group	Chair
15.	Advocacy Service	VoiceAbility
16.	London Borough of Hackney	Assistant Director Adult Social Care
17.		
18.	Hackney Borough Command (Met. Police)	Public Protection lead
19.	London Borough of Hackney	Head of Safer Communities
20.	London Borough of Hackney	Head of Housing Needs
21.	London Borough of Hackney	Head of safeguarding Adults Service

The Board met six times during 2013-14, with an Independent Chair. Sub-groups of the Board were reviewed at a board development day,

City & Hackney Safeguarding Adult Board Governance



Appendix 2: Reports from individual agencies

2.1 The City of London Safeguarding Adults Report 2013/14

Overview

This Annual Safeguarding Adults report details what has been achieved in the City of London Adult Social Care Service during 2013/14 and Safeguarding Adults arrangements have become embedded over the last year in relation to our core strategic aims and values.

The City has a resident population of 7,400, found in densely populated pockets of the square mile. The resident population, of 4,400 households, has grown slowly over the last decade, but is projected to grow more rapidly to reach 9,190 by 2021. In addition to those who live permanently in the City, there are also 1,400 people who have a second home in the square mile. Average household size in the City is the lowest of all the local authorities in England and Wales with 56 per cent of households comprising one person.

Growth in the City's population in the next decade is expected to be most rapid among those aged 65 and over. Life expectancy in the City is very high, but an increase in the aging population is likely to bring with it an increase in age related health difficulties such as reduced mobility, dementia and social isolation, as well as the need for additional support and care. With increased vulnerability, as a consequence, safeguarding will also become an increased risk factor.

The City's population is predominantly white (79 per cent) with the second largest ethnic group being Asian (13 per cent) – a group that include Indian, Bangladeshi and Chinese populations, which has grown over the past decade. The size of the Black population is smaller in comparison to both the London wide population and that of England and Wales.

Meeting the escalating demand for social care services is acknowledged as one of the greatest challenges the department will face in the next three years. We have an aging population and more vulnerable adults potentially needing support and assistance to maintain their independence and dignity. We have high numbers of older adults living on their own and at risk of social isolation. The City has the sixth highest number of rough sleepers. This group is intensely vulnerable to chronic alcohol and drugs use as well as acute mental health, which present major risk factors.

We will continue to fulfil our duties to safeguard those who are most vulnerable whilst targeting the resources we have to ensure we achieve maximum value for money.

Safeguarding Arrangements

The Community and Children's Services (CCS) Departmental Business Plan 2014-17 states "that we have a wide remit to provide safeguarding, care and support to the residential population of the City of London".

The Adult Social Care (ASC) service also has a duty to ensure that those people placed outside the City of London, in care homes and supported living settings, are also safeguarded through collaborative working arrangements with relevant host authorities.

As part of the CCS strategic aims, Adult Social Care is required to report the number of Adult Safeguarding Alerts within the City and those outside on a quarterly basis.
In terms of governance arrangements, the safeguarding adults agenda is placed alongside safeguarding children in respect of the work of the Member led Safeguarding Sub-committee (a Sub-Committee of the Community and Children Services Grand Committee), which last year replaced the corporate parenting task group. This has ensured that Members of the Court of Common Council are now presented with quantitative and qualitative evidence in respect of the arrangements to safeguard adults in the City of London. Furthermore, an elected member of the Court of Common Council and Member of the Safeguarding Sub-Committee is also now a member of the City and Hackney Safeguarding Adult Board.

At officer level, the City of London Safeguarding Adults Subcommittee has been confirmed as a Sub-Committee of the City and Hackney Safeguarding Adult Board and is chaired by the Assistant Director for People Services.

During the year, ASC has continued to build on partnership arrangements across the health landscape to support improved information sharing, processes and interventions that seek to be person centred, in the right place and at the right time. This work has drawn on the need to develop integration plans in respect of the Better Care Fund which in turn has also been concerned with the business of safeguarding, through seeking to forge more substantial collaboration and referral pathways for early intervention and prevention.

As such, we have sought to establish greater links and integration with health across the main routes for hospital discharge with 2 Acute Trusts, Bart's Health and UCLH, together with seeking to build partnerships with primary health across 3 Tower Hamlets GP practices, 1 in Islington and continuing to work closely with the 1 City and Hackney CCG GP practice within the square mile. ASC have a designated social worker whose role is to work with all GP practices where City of London residents are registered to ensure consistency and continuity of care and support is maintained, which has a direct correlation with safeguarding and the early intervention and prevention model that the City has adopted.

Achievements

- *Dementia Strategy*

The work around the Dementia strategy has centred on the work with the Alzheimer's Society and Skills for Care together with the ASC Dementia champion in seeking to make the City more dementia friendly. Since the start of the strategy implementation there has been a rise in the numbers of safeguarding alerts that relate to people with a dementia diagnosis (3 in total.)

As greater understanding on behalf of partners, such as Police and Housing officers has increased, greater community intelligence has been raised regarding potential adults at risk who are experiencing cognitive impairment due to Dementia. Multidisciplinary protection plans have been formulated to ensure the persons safety and importantly their ability to remain in their own home.

One elderly woman was referred by housing and community police officers who had reported that persons had broken into this woman's home. It transpired that this woman was living with Dementia and she had become acutely unwell experiencing periods of delirium and a delusional state. This case is an example of a safeguarding alert being received but not being pursued via the safeguarding route, but support and ongoing care being offered in a collaborative manner though ASC, CPN and Psychiatrist. This woman was successfully treated in the community and remains in her own home.

- *Prevention and keeping people safe- partnership working*

ASC has continued to work closely with the London Fire Brigade over 2013/14. 86 ASC service users were identified as being most vulnerable and at risk of harm as a result of fire. The process is well underway with heat and smoke detectors being installed through the telecare offer, as well as fire safety ashtrays being issued where appropriate. The Supported Assessment Questionnaire, under the Keeping Safe section, now contains a check question, to ask whether the social worker has considered fire safety as part of the assessment.

Adult Social Care continues to work with partner agencies to strengthen arrangements for community safety, such as working closely with the Multi Agency Risk Assessment Conference (MARAC) and the Multi Agency Public Protection Arrangements (MAPPA). There has been consistent engagement and attendance at these fora throughout the year.

Regular meetings are held with housing estate and community policing and ASC staff to discuss vulnerable residents, and possible referral to ASC as well as possible adults at risk of abuse. Monthly meetings are chaired by ASC to discuss concerns regarding the mental health of rough sleepers, with Police, ELFT CPN, Broadway and the Rough Sleepers Service.

- *Safeguarding Awareness Raising*

In March 2014 Safeguarding was added to the City of London Corporate strategic risk register. A Corporate safeguarding policy was also produced to act as a source of reference and understanding throughout the Corporation.

In addition to this, and as part of the DCSS transformation agenda, there has been the development of a Safeguarding Awareness Raising campaign, called Notice the Signs.

The Campaign is targeted at two distinct audiences:

- City of London Employees (including members and partner agencies)
- City of London residents.

The primary aims of the campaign are:

- To improve general knowledge, understanding and awareness of the City of London's role in safeguarding adults and children at risk
- To ensure that City of London staff understand their responsibilities and roles in safeguarding
- To raise awareness among City of London residents of what constitutes abuse and what is an Adult at Risk. To provide them with information and advice to ensure that they know what to do and who to call if they wish to discuss concerns and raise an alert.

The safeguarding campaign to residents will be launched in September –December 2014. The campaign has been approved by all City of London's Safeguarding Committee's together with the City and Hackney Safeguarding Board.

- *Learning and Development*

Last year as part of the Winterbourne review and stocktake, ASC worked on a best practice model to emphasise quality reviews of all residential placements for all service users, not just those with a Learning Disability**.** ASC have 13 Service Users with a Learning Disability. 7 live within the City and receive support within their own homes and 6 are in placements outside the City. ASC continue to have funding responsibility for those placed outside the City, and review each person every 6 months. None of the adults the City work with currently would meet the criteria of an adult with challenging behaviour and complex Learning Disabilities, as was the case for those Adults who resided at Winterbourne View, which was a health funded assessment unit.

ASC used best practice principles to redefine our Statutory Review process for all adults in a care home settings, regardless of their Learning or Physical Disability, Mental Health or Age, and revised our review template to have a more focused and personalised support plan, that looked in more depth at medication and possible over use of anti-psychotics. New outcomes for the review were set out as follows; the social worker will always seek to meet the key worker, home GP or home nurse to discuss medical needs; to always invite family members and document relatives' views as well as the service user's wishes and feelings where ever possible; to assess capacity at each review.

City review documentation and established workforce practices did already lend themselves to this personalised approach to Care Home Reviews, but Winterbourne tightened up the importance of sound professional social work reports with an emphasis on reading medical notes and meeting as part of the multi-disciplinary team when holding the review, and making the home more accountable for its actions. The main area that the ASC service have formalised is to raise the status of the review and designate a qualified social worker who has Care Home Reviews as her specialist area. Another important outcome has been awareness in the need to

carry out unannounced visits to placements where our service users are living. This challenges providers to maintain high standards and transparency at all times, especially when service users do not have any frequent visits from relatives. The Winterbourne Stocktake messages and lessons learnt have been demonstrated through the above practice within Adult Social Care.

Adult Social Care has continued through contract monitoring and review, to maintain awareness with commissioned services regarding safeguarding. This has been incorporated into all meetings with Toynbee 50+, CSV shopping and befriender service, City Carers Advice and Information, together with Age UK Camden who run the Memory Lane Café.

Any Alerts involving domiciliary care providers are reported to the Commissioning team who would attend strategy meetings where necessary. Commissioning is currently working on a review of all contracts to insure they comply with safeguarding and mental capacity requirements.

In November 2013 an independent quality assurance review of safeguarding adults arrangements was conducted over a period of 3 days. The review was undertaken by an independent freelance consultant who specialises in the field of safeguarding adults. The review was jointly commissioned by both City and Hackney, although specific reviews took place in each authority. It was agreed upon at the outset that judgements would be measured according to the “outstanding” matrix as defined by CQC and SCIE .3 cases were independently chosen by the reviewer and analysed against an audit tool.

The overall headline findings were as follows:

- Of the 3 cases examined, one was found to be excellent, one very good and one satisfactory overall.
- Recording was very good in 1 case and satisfactory in 2 cases
- Knowledgeable and competent management of safeguarding work in place
- General adherence to the London Policies and Procedures
- Quality of protection planning is good
- Follow-through on protection plans is evident
- Personalisation / Prevention is evident
- Engagement of other agencies is evident
- Outcome, closure and review stages evident.
- Positive development of the strategic joint city and hackney safeguarding board
- Development required around publicity and public awareness of safeguarding needed through information systems via website and information literature.

An improvement plan has been drafted to support implementation of development areas which will be reviewed by the Safeguarding Adults Board subcommittee and progress reported back to Member led subcommittee. The same independent reviewer will carry out a further review in 2014 to assess quality of implementation of the findings as well broaden scope to look in more detail at the safeguarding system in the City.

- *Adult Safeguarding Self-Assessment*

Following a City and Hackney Safeguarding Adult Board development day in February 2014, it was agreed that the board would adopt the new Safeguarding Adults at Risk Audit Tool, as part of the Safeguarding Adults assurance process to strengthen inter agency working and processes. The tool was developed by NHS England in conjunction with the Safeguarding Boards Network.

The self-assessment process identified that the City of London adult social care service meets 18 of the 22 requirement's, with 4 assessed as requiring additional action. No reds were identified. Review of the findings will be driven through the Quality Assurance sub group.

- *The Voice of the User*

In working to prevent abuse and to keep people safe, it is essential to have the "voice of the user" to understand what makes people feel unsafe, what is it that makes them feel vulnerable and what interventions they need to address this. During 2013/14 the Adults Advisory Group (AAG), which has representation on the Adult Safeguarding Sub-Committee, has been kept informed and consulted on a number of policy and practice issues. The AAG is chaired by a Member of the Court of Common Council and is represented by service users and residents from across the City. It is hoped that there will also be service user representation on the City and Hackney safeguarding board in 2014 alongside the development of various focused subcommittees to look at specific safeguarding matters in more detail, such as quality assurance and qualitative safeguarding outcomes and user feedback.

Making safeguarding personal has been a key theme for ASC and we have devised a simple outcomes data collection model which asks people after the safeguarding process how safe they now feel on a scale of 1-10. This is a new workflow devised through the social care electronic recording system Framework I, and we anticipate reporting on this outcome of this feedback survey following an intervention for the next Annual report.

New Developments

- *Deprivation of Liberty Safeguards*

There has been one DOLS authorisation over the period.

A Supreme Court Ruling in March 2014, has redefined how a Deprivation of Liberty must be viewed under the auspices of the Mental Capacity Act , and this in turn has meant that the number of people we currently support in care homes and also now in supported living are being reviewed by a Best Interests Assessor. ASC currently accommodate 33 people in supported living and 32 people in a care home. There is a potential that due to those service users lack of capacity, the City may have to safeguard them further via a DOLS authorisation, as well as apply to the Court of

Protection. Progress on the implementation of the response plan will be reported in the next Annual Report.

Future developments

- To continue to develop effective partnerships with key agencies such as CCGs, CQC, Police, Housing and Advocacy, particularly with the focus of the Care Act 2014.
- To continue to develop a high level of safeguarding competence in the ASC workforce and with partners.
- To evaluate the improvement plan and undertake a review of our safeguarding practices
- To raise awareness of Adult Safeguarding to City of London residents, through the campaign launch, Notice the Signs, in September 2014, in order that communities and organisations know how to respond effectively when they suspect that an adult is at risk of abuse.
- To ensure that in the City of London we are actively identifying and preventing the circumstances where abuse occurs and promote the welfare and interests of adults at risk.

2.2 Metropolitan Police Service

Overview

The Metropolitan Police Service (MPS) has a duty to work in partnership to protect the most vulnerable persons in society. Like many other public authorities, the police are frequently the first point of contact for a vulnerable person in crisis. Officers need to be able to recognise risk and identify early intervention opportunities to support and protect.

The MPS is committed to the protection and safeguarding of all adults at risk and is a partner to the pan London multi-agency safeguarding adult procedures. Operational toolkits are currently under review and new instructions for the risk assessment and research of potential safeguarding adult incidents are due for publication. Pan London Proposals for the Protection of Vulnerable Persons are currently being considered by the MPS Management Board.

Any allegations of crime involving a vulnerable adult where abuse, neglect or ill treatment is alleged will be managed by experienced investigators within the Community Safety Unit. These officers have received enhanced training to reduce the impact of the investigation upon the victim by the use of special measures and intermediaries.

An intermediary is somebody who can help a vulnerable witness understand questions they are asked and can communicate the witnesses' response. They help witnesses at each stage of the Criminal Justice process, from police investigations and interviews, through pre-trial preparation and at court. Intermediaries perform an

important function, helping the most vulnerable members of our society gain equal access to justice.

The MPS has a corporate management structure with rank specific areas of responsibility. All staff have access to legal services for any complex legal advice required for Adult Safeguarding cases. Staff are supported by operational instructions that inform them of their responsibilities under the Mental Capacity Act and they have Strategic Support Units to provide operational support and advice as required on safeguarding and mental health issues.

Safeguarding Activity

During this reporting period, MPS Hackney recorded 15 allegations of crime involving a vulnerable adult. It is anticipated, this will increase as employees and society become more aware of safeguarding responsibilities. A number of allegations are still under investigation, but 2 resulted in positive case disposals. In the case of a carer being verbally abused, the suspect was warned under the Protection from Harassment Act 1997.

The police conducted a parallel investigation in partnership with the Care Quality Commission and NHS Trust during another more complex allegation. This is still progressing through the criminal courts, but resulted in a member of staff being charged with willful neglect of a person without capacity, under section 44 Mental Capacity Act 2005.

Adult Safeguarding has significantly changed over the last few years across London. Historically, London boroughs were operating to different policies and procedures with little structure for recording and referrals. The creation of the MPS Safeguarding Adults policy in 2012 was the first step towards a pan London procedure, supported by the NHS and Adult Social Care.

In April 2013 the MPS began to record encounters with vulnerable adults (persons over the age of 18) who came to the attention of police. Whether as a victim, witness, suspect or member of the public, these encounters are now recorded on the MERLIN system as an Adult Coming to Notice (ACN), where:

a) there is a concern of vulnerability in one or more of the following aspects:

1. Physical
2. Emotional/Psychological
3. Sexual
4. Acts of Omission / Neglect
5. Financial

and

b) there is a risk of harm to that person or another person.

The MPS also record all Section 135 and 136 Mental Health Act incidents on ACNs (Sec 135/6 reports are for record only). Non Section 135/6 reports will be reviewed and researched by the Multi-Agency Safeguarding Hub (MASH) to identify risk and cases which require a referral to an appropriate agency for intervention. Except during weekends, this process must be undertaken within 24 hours, supervision is a mandatory part of the process before reports are closed by the MASH Supervisor.

It is imperative that police officers ask the person coming to notice for consent to share their personal details with partner agencies. Without consent the MPS should not share this information.

Police officers and staff are not medical professionals; it is unrealistic to expect them to be able to identify all forms of mental illness. Therefore officers are being trained to identify those that are vulnerable and which referral pathways they can use. The number of ACN reports received by Hackney MASH fluctuates. Reporting levels are circa 5-10 ACN each day; however, as was seen when the MPS first began recording CTN (Child Coming to Notice) on MERLIN, numbers will increase in line with staff awareness.

Training

Historically, MPS staff have not received mandatory Adult Safeguarding training, it used to feature as part of other hate crime training e.g. Domestic Abuse. Since January 2014, all frontline staff receive mandatory training on the 'Vulnerability Assessment Framework'. This is currently being rolled out across the MPS and will therefore be measurable for compliance.

Case example JM: Merlin report received on 13.4.14 advised

"Officers opinion is that this subject is vulnerable, due to his inability to communicate or defend himself should there be unwanted visitors or an intruder. The house has bars on all windows, but multiple persons are entering the premises as carers, who may also bring along unknown others. The rest of the house is full of his recently deceased mother's possessions, which his next of kin believes is being searched."

As this client (J.M) was known to Adult Social Care, the allocated Social worker arranged for a Safeguarding Adult strategy meeting, in which the above allegations were investigated and protective measures put in place. These included:

- Further Police investigation
- Ongoing service delivery investigation of service provider by Contracts Team
- Safeguarding Adult fuller investigation
- Review of clients care needs and suitability of current accommodation
- Fire safety referral
- Referral to bereavement services re the recent demise of J.M's mother

Client was supported to remain within the property with a reconfigured care package as this was what he stated was important to him.

Social worker continues to monitor and review support, working with client, his family and other voluntary, statutory and health services in ensuring that client receives a joined up service.

The Safeguarding Adult Team was also able to interview JM as part of the work being undertaken in conjunction with the Health and Social Care Information Centre (HSIC). Here a Safeguarding Adults pilot study is being completed, in a bid to make safeguarding more personalised. J.M was able to advise that he was able to understand all the information given to him when people were trying to help him stay safe and as a result of protective measures he felt quite a bit safer.

2.3 London Fire Brigade

Overview

The London Fire Brigade has two detailed policies around safeguarding (one each for adults and children). Operational staff and other staff groups who may come into contact with vulnerable people are aware of the actions to be taken. The issue will be reported to the Officer of the day (OOD) within 4 or 24 hours depending on urgency. The OOD will inform the duty Deputy Assistant Commissioner (DAC) who will assess the situation against set criteria and make a decision whether or not to make a safeguarding referral to the local Social Care Department or to treat as a welfare referral.

The London Fire Brigade has a strong commitment to safeguarding both adults at risk and children. The appointed lead officer for safeguarding is the deputy head of community safety, who has responsibility to 'champion' safeguarding throughout the organisation. The lead officer is supported by members of the central community safety team in discharging this function. All new staff are made aware of their responsibilities to safeguard adults at risk and children and promote well being. Staff utilise internal safeguarding procedures for managing referrals to local authorities in a consistent and robust manner.

Each London Fire Brigade (LFB) Borough Commander sits on their local SAB and the LFB is also represented at the strategic level London Safeguarding Adults Network meeting.

The organisation's commitment to inter-agency working can be found in strategy documents such as the London Safety Plan – Fifth version, endorsed earlier this year by the London Fire and Emergency Planning Authority, the body responsible for governing the LFB.

Safeguarding activity

LFB personnel in Hackney made one safeguarding and three adult welfare referrals between April 2013 and March 2014. Officers refer to the appropriate agency through safeguarding protocol where evidence suggests this is necessary and make welfare referrals where appropriate. London Fire Brigade have made a number of referrals throughout the year in accordance with Brigade policy which defines a safeguarding referral as a situation where a person is being abused, as opposed to a welfare referral which is generated when a serious risk is identified to a person's welfare. Of these one has been referred through the urgent safeguarding referral process. The remainder have been treated as welfare referrals and referred to appropriate services and agencies within the borough.

Training

Although no formal training is carried out for operational LFB staff, the two polices related to Safeguarding will be covered annually during lecture periods. Members of staff within our Community Safety department that work specifically with children and young people receive bespoke safeguarding training.

Copies of the policies are also available to staff at all times to inform their decision making if they are in a situation with a potential safeguarding issue.

Key developments for 2014/15

London Fire Brigade will continue to build links with partner organisations in the borough to raise awareness of the risks to adults from fire. We will build on work to highlight the increased fire risk for people with mental health problems, the dangers of hoarding and to promote the provision of arson proof letter boxes and fire retardant bedding. LFB will support partners by providing advice in relation to fire safety in the home and by promoting domestic sprinklers for those deemed to be at very high risk from fire.

Both safeguarding policies (Adults at Risk and Safeguarding Children) are currently under review by the central community safety team. Work is underway to update data transfer methods and compile a centrally held safeguarding referral database which will identify safeguarding trends pan London and those who have been previously referred. When the policy review has been completed an appropriate training input for all staff at all levels will be rolled out across the service.

2.4 Homerton University Hospital NHS Foundation Trust

Overview

This report provides an overview of activities aimed at safeguarding vulnerable adults during the period 1st April 2013 to 31st March 2014. It contains an update on the work planned to strengthen the Trust's systems and processes which are important in improving quality of our work to safeguard vulnerable adults.

The profile and awareness of the importance of safeguarding vulnerable adults has increased, particularly in the wake of poor care revealed by covert filming in care facilities and the publication, in February 2013, of the Francis report into the failings at Mid Staffordshire NHS Foundation Trust. This report should be viewed in the wider context of action in Homerton and in response to the Francis Report. In addition, there has been recognition that the statutory framework for safeguarding vulnerable adults has lagged behind that for safeguarding children.

The Care Quality Commission (CQC) the regulator for health and social care in England, assesses whether hospitals, care homes and all other care services provide people with safe, effective, compassionate and high-quality care. The CQC makes judgements using criteria set out in the Essential Standards of Quality and Safety. Safeguarding (Outcome 7: Safeguarding people who use services from abuse) is one of the 16 Essential Standards most closely related to the quality of patient care. CQC inspections of the services provided by Homerton and their involvement in the safeguarding processes led by London Borough of Hackney (LBH) and the City of London also provide assurance of the quality of Homerton's safeguarding functions.

This report highlights activities and achievements against the main indicators or headings used in safeguarding adults self-assessment frameworks[2]. The main priorities for improvements during 2014/2015 are summarised at the end of each section.

Safeguarding Activity

A: Leadership, strategy, governance, organisational culture

In January 2014, Homerton published its organisational strategy called 'Achieving Together: working towards 2020'. This strategy sets out the priorities, goals and values of the organisation and was developed through broad based consultation with patient representatives, staff, external partners and other stakeholders. Homerton's mission is:

Safe, compassionate, effective care provided to our communities with a transparent, open approach.

The mission and strategy are underpinned by a set of four core values each of which is relevant to safeguarding adults

- Safe
- Personal
- Respectful
- Responsibility

The work on developing the vision and values at Homerton took place during 2013 and helps to inform the work specifically focused on safeguarding.

i. Developing shared safeguarding principles

A shared view of safeguarding principles was developed through a joint workshop held in October 2013 which brought staff involved in safeguarding children and adults together. These principles have been used to inform the safeguarding adults workplan 2014/2015.

Safeguarding principles

- A whole family approach
- Provide high quality services which deliver evidence based practice that is built on and connected to the Homerton's values
- The safety of our patients and clients is everyone's responsibility
- Effective and appropriate training for all. This is underpinned by life-long learning, learning from incidents and training models that demonstrably improve competence and confidence.
- Effective multi-agency working and information sharing
- Listening to the voice of the child or vulnerable adult
- A focus on awareness of safeguarding and prevention

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ii. Changes in the safeguarding adults team

Homerton's leadership for safeguarding adults underwent major changes during 2013/2014. The Chief Nurse and Director of Governance is the executive lead for safeguarding and changed in July 2013 with the appointment of Sheila Adam.

The Head of Safeguarding Adults changed hands in 2013. Unfortunately this meant the post was vacant for a total of seven months during 2013/2014. The Lead Nurse for Vulnerable Adults left Homerton in March 2014 and the scoping of this role is a priority for 2014/2015. Throughout 2013/2014 there was regular contact between safeguarding staff and staff providing clinical services. Contingency arrangements were also put in place to support clinical staff particularly with complex safeguarding adults cases. The Safeguarding Adults Committee met four times monitoring the safeguarding adults workplan and helping to shape the changes in policies and procedures as well as the safeguarding priorities.

iii. Meeting CQC standards

In the inspection carried out to assess Homerton's community based services in December 2013 and January 2014, CQC found that Homerton met Essential Standard Outcome 7: Safeguarding people who use services from abuse.

CQC inspectors found that:

- People who used the service told us they felt safe with staff. One person using the service told us, *"I feel safe here as I have always had the same midwife, which means I can connect with them."*
- The Trust had policies and procedures for safeguarding vulnerable adults and children, as well as a whistle blowing policy for staff.
- The staff we spoke with demonstrated a good understanding of safeguarding issues and knew how to respond. We asked some members of staff how they would respond to safeguarding scenarios and they provided safe and appropriate answers.
- The Trust's training records showed that staff had attended safeguarding training, as well as training about mental capacity, consent to care and deprivation of liberty. Staff told us that senior staff spoke with them about safeguarding as part of their regular individual and group supervision meetings

In February 2014, CQC under the Chief Inspector of Hospitals examined and rated the care provided at Homerton University Hospital. The inspection team included doctors, nurses, and hospital managers, trained members of the public, CQC

inspectors and analysts. The inspection team carried out an announced inspection visit in early February.
They examined the care provided in A&E, medical care (including older people's care), surgery, intensive/critical care, maternity, children's care, end of life care and outpatients.

Inspectors also visited the hospital unannounced as part of the inspection, held focus groups with staff, and held a public listening event. The report which CQC published in April 2014, was based on a combination of their findings, information from CQC's Intelligent Monitoring system, and information provided by patients, the public and other organisations.

CQC rated whether services were:

- Safe
- Effective
- Caring
- Responsive
- Well-led

Using a four point scale of 'outstanding', 'good', 'requires improvement', 'inadequate'. The table below is a summary of the ratings for each of the eight services inspected as well as for the hospital overall.

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Outstanding	Not rated	Outstanding	Outstanding	Outstanding	Outstanding
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Intensive /Critical care	Good	Good	Good	Good	Good	Good
Maternity & Family planning	Good	Good	Good	Good	Good	Good
Children & young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Requires improvement	Good	Good
Out-patients	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Homerton is required to take action on three compliance actions set out below. The first two actions are related to the 'requires improvement' rating for the 'Is care safe?' domain:

1. The Trust must take appropriate steps to ensure that at all times there are sufficient members of suitably qualified, skilled and experienced staff employed on the medical wards.
2. The Trust must ensure that patients are protected against the risks of unsafe or inappropriate care and treatment by means of accurate record keeping, which should include appropriate information and documents in relation to the care and treatment planned and provided to each patient**.**
3. The Trust must ensure patients and/or their relatives are involved in 'do not attempt cardiopulmonary resuscitation' (DNAR CPR) decisions and ensure these are adequately documented.

A comprehensive action plan has been formulated and is being monitored via the Quality and Patient Safety Board and the Trust Management Board.

Priorities for action 2014/2015:
Leadership, strategy, governance and regulatory standards

- Staffing: ensure there is a full complement of dedicated safeguarding adult staff and build a network of safeguarding champions who will provide peer support and act as a source of expertise within services.
- Governance via overarching safeguarding committee which will meet bi-monthly. Adult safeguarding group will also meet bi monthly to examine adult specific issues.
- Representation and participation in CHSAB and North and East London network
- Culture – Duty of candour indicators
- Audit of the timeliness and quality of Notifications to CQC under Health and Social Care Act 2008, Regulation 18 including 'allegations of abuse'.
- Preparation for Fundamental Standards Regulation 13 safeguarding (which becomes law from April 2015).

B: Responsibilities towards adults at risk are clear for all staff and for commissioned services

Many of the key policies and processes that support staff in recognising and responding to adults at risk were revised during 2013/2014. Examples include:

- *Safeguarding vulnerable adults policies and procedures, 2013*. This simplified the reporting of incidents and aligned it to the seven steps in the Pan-London process.
- *Patients Subject To The Mental Health Act (May 2013)*. This policy was developed to help ensure that the Trust meets its legal responsibilities in relation to the Mental Health Act 1983 and appropriately protects the rights of patients detained under the Mental Health Act within the Trust.
- *Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) policy, July 2013.* This policy provides guidance on the local policies, practice and procedures that should be followed by Trust staff when working with individuals who have difficulty decision-making. It is intended to ensure that all staff act in accordance with the relevant legal framework.

Priorities for action 2014/2015:
Policies and practice informed by legal frameworks and enquiry recommendations

- Review the safeguarding policies in light of changes in the legal framework underpinning safeguarding e.g. Care Act 2014 and the Cheshire West and Surrey County Council judgements.
- Develop a system for communicating relevant updates from case law, Court of Protection rulings and European Court of Human Rights judgements.
- Review the commissioned and contracted services requirements to demonstrate that the MCA is complied with in conjunction with safeguarding children.

Revise the recommendations for action developed following the enquiry into the activities of Saville in NHS organisations.

C: Organisation's approach to workforce issues reflects a commitment to safeguarding and promoting the wellbeing of adults at risk

Homerton is committed to carrying out robust and safe recruitment procedures and practices. Assurance that these procedures are followed is provided by the monthly performance reports within each of the service divisions.

There is good evidence that the more engaged staff members are, the better the outcomes for patients and the organisation generally. The Trust encourages staff to participate in the annual national NHS staff survey and the quarterly staff 'Friends and Family Test[3]'. The NHS staff survey 2013 showed that Homerton was in the top

[3] The staff Friends and Family Test is a confidential survey administered by The Picker Institute. The survey asks two questions and answers range from 'extremely likely' to 'extremely unlikely'

- How likely are you to recommend "your trust" to friends and family if they needed care or treatment?
- How likely are you to recommend "your trust" to friends and family as a place to work?

20% of trusts for staff who were highly engaged in their work, in their team, and in the Trust. Homerton is also in the top 20% of trusts providing opportunities for staff personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

Fostering an open transparent approach is central to the Trust's mission and is particularly important in encouraging and enabling staff to report any safeguarding adults concerns. Homerton has signed up to the Nursing Times 'Speak out safely' campaign which encourages any staff member with a genuine patient safety concern to raise this within the organisation at the earliest opportunity.

Training on the key principles of safeguarding adults is part of the statutory and mandatory training delivered at the induction of all new members of staff. Safeguarding adults is also part of the annual mandatory update which was delivered to all staff via a training booklet in 2013/2014. The table below shows that the average percentage of staff trained at level 1 in 2013-2014 was 95.59%. These figures are reported to the Trust Board each month as part of the report on the quality of services provided.

Safeguarding Adults Level 1 Mandatory Training Completed (%)

Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014
95.99	94.36	93.22	90.55	91.63	91.16	98	99.97	99.97	99.94	96.60	95.69

Safeguarding adults level 2 training is provided as a mixture of bespoke courses and mandatory clinical updates in for example the maternity service. Safeguarding adults level 3 training: focused on staff undertaking an investigation when a safeguarding alert has been raised. The table below shows the level of the uptake of training as of May 2014.

Safeguarding Adults training level	Number of staff requiring Safeguarding Adults training at specified level	Number of staff completing training	% of staff trained
Level 2	784	754	96.17%
Level 3	37	36	97.30%

Whilst the uptake of training at all levels is excellent, it is unclear whether the training models in place during 2013/2014 enabled all the right staff to feel confident and competent to recognise safeguarding adults concerns and take the appropriate action. Analysis of a proportion of incidents reported as safeguarding adults concerns during 2013/2014 highlighted the complexity of many of the issues surrounding adult safeguarding in diverse and deprived communities in Hackney and

parts of the City. The priorities for 2014/2015 are summarised in the box below and have been shaped partly by this analysis.

Priorities for action 2014/2015:
Developing a competent and confident workforce in adult safeguarding informed by staff and patient feedback

- Develop a comprehensive safeguarding adults training plan to include competencies at each level of training by job role, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training, Best Interest Assessor training, Safeguarding Alert Management and safeguarding adults investigation
- Develop methodology for assessing safeguarding adults competencies pre and post training.
- Develop a programme of Prevent training and awareness
- Ensure analysis of staff and patient feedback from 'rounding' style visits, complaints, incidents and PALS enquiries relevant to safeguarding adults is used in training programmes and service improvement

Develop a process for providing feedback to staff who report adult safeguarding concerns

D: Effective inter-agency working to safeguard and promote the wellbeing of adults at risk

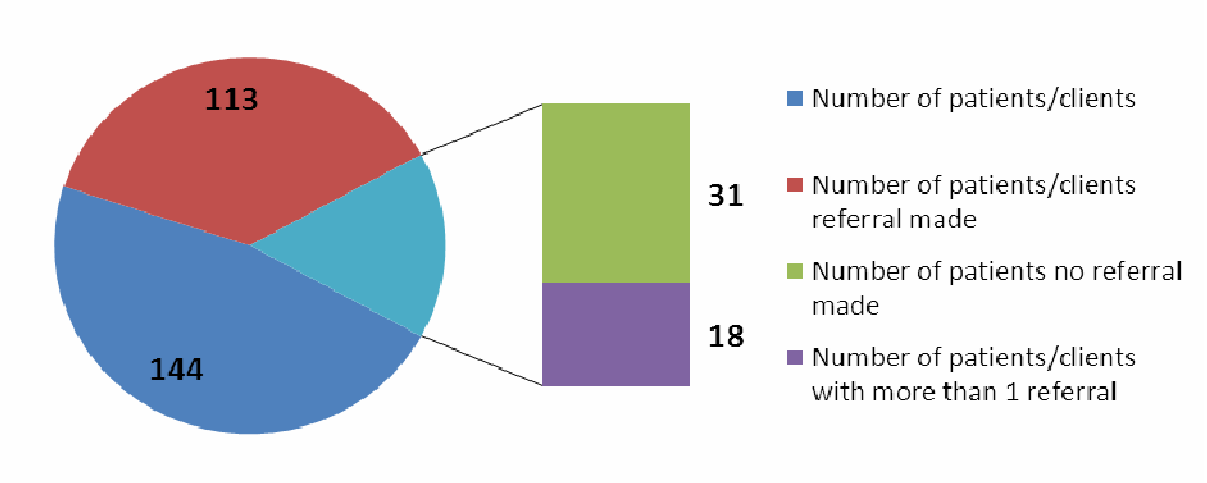
Homerton has been an active participant in multi-agency safeguarding adults meetings such as the North East and Central London Safeguarding Network and the City and Hackney Safeguarding Adults Board (CHSAB).

The Trust executive lead for safeguarding is a member of the CHSAB Executive and has disseminated findings and action from the CHSAB. Trust staff have completed safeguarding adult referrals in line with the Pan-London guidance and have participated in strategy meetings and case conferences. However, the Trust recognises that there were gaps in the consistency and timeliness with which safeguarding adults referrals were submitted and the systems for capturing the lessons and outcomes from these referrals needs to be strengthened.

As noted above, Homerton's process for reporting referrals and incidents regarding safeguarding adults was revised in autumn 2013 following a consultation exercise undertaken with staff by Head of Adult Safeguarding. The process was simplified to mirror the seven step Pan-London guidance. Homerton staff were required to report all safeguarding related incidents on the central Datix incident reporting system.

Whilst there is an 'adult protection' category that staff may use when reporting incidents, categorisation of incidents can vary according to the type of safeguarding incident. Some staff use the 'Category' box to indicate the type of abuse witnessed e.g. violence, harassment etc. The charts below were derived from analysis of a sample of incidents reported between March 2013 and April 2014. All the incidents including in this analysis were categorised as 'adult protection' related.

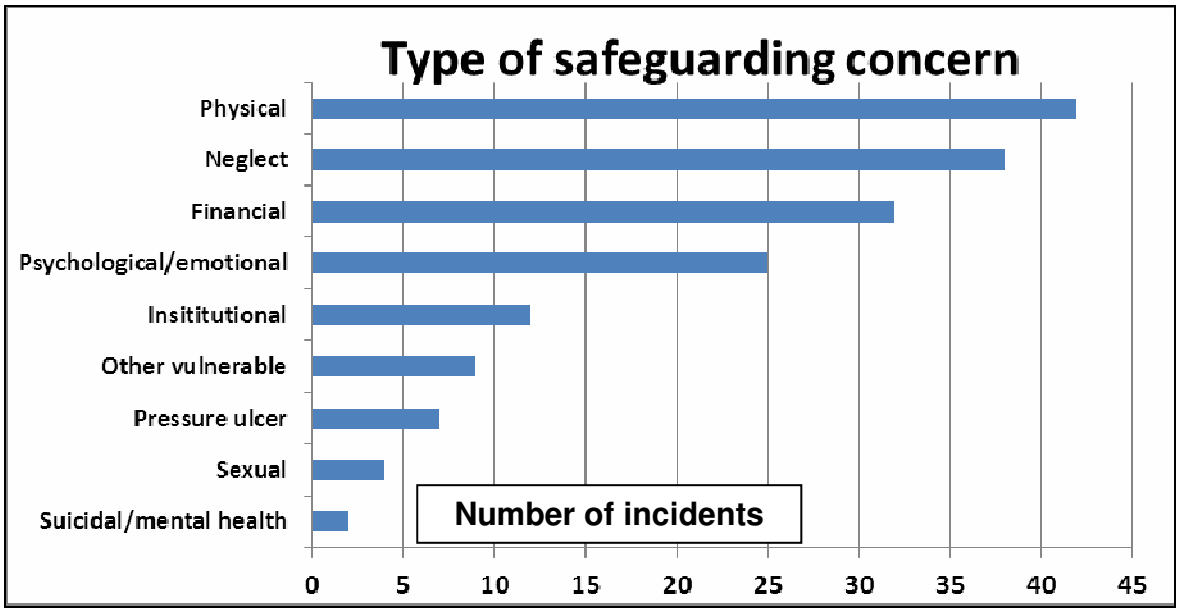
Analysis of incidents reported under the category 'adult protection' during March 2013 to April 2014



162 incidents were reported as adult protection and these involved 144 patients. 18 patients had more than one incident report (mainly 2 reports, though one patient had 3 reports). A patient may have more than one incident on the same ward, or more usually when they have moved ward or service e.g. moved from Graham ward to Mary Seacole Nursing Home.

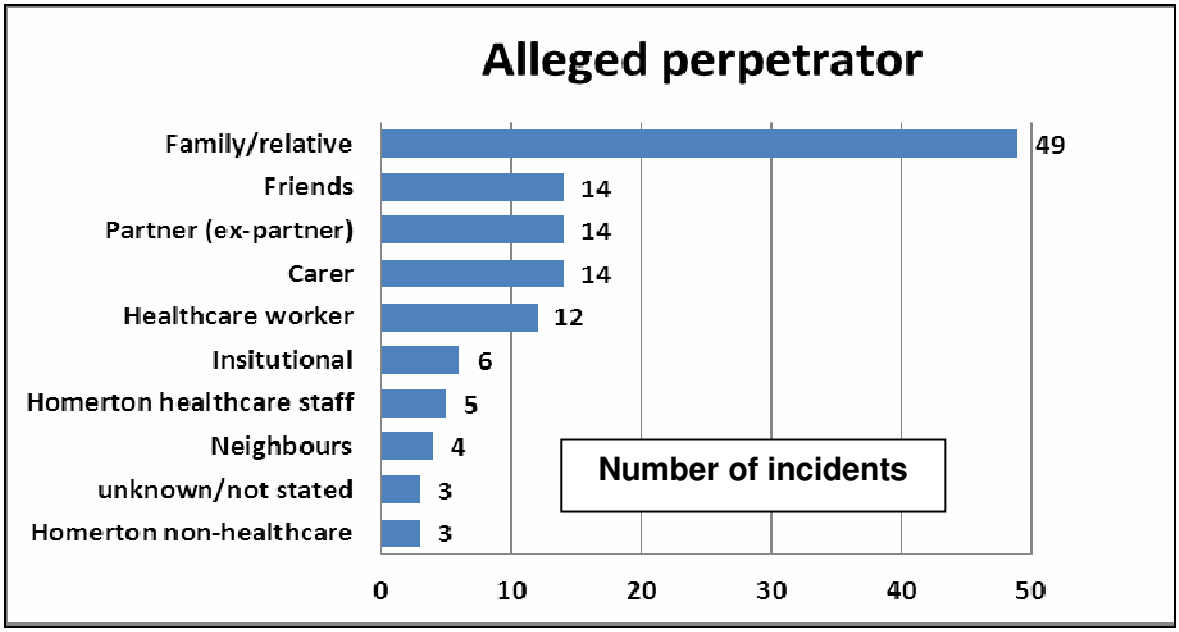
31 patients out of the 144 patients did not have a safeguarding referral. This is consistent with the fact that not every adult safeguarding incident meets the threshold for a referral. Analysis of the incidents where a safeguarding referral was not made showed that staff used the adult protection category to signal that the patient would need particular attention or arrangements for discharge planning for example. In addition, there were a small number of cases involving pregnant women or women with children at risk so the safeguarding approach taken was via safeguarding children processes. Most, but not all safeguarding referrals were made to LBH. Referrals were also made to the London Boroughs of Islington, Newham, Tower Hamlets and Waltham Forest.

The 162 incidents were examined to see the types of abuse noted and the alleged perpetrator of the abuse.



Please note that an incident may involve more than one type of safeguarding concern, for example financial abuse together with psychological/emotional abuse. The pressure ulcers category includes ulcers (grade 3 and 4) acquired in the community (mainly in nursing homes). There have been 5 grade 3 ulcers attributed to Homerton between January and March 2014. A task group to examine and take action on pressure ulcers was set up during 2013, led by a divisional Head of Nursing for acute services.

The chart overleaf shows a categorisation of the 'alleged perpetrator' involved in the adult protection incidents. It is striking that some of the 'alleged perpetrators' are themselves vulnerable due to 'hidden harms' such as substance misuse or mental health problems.



Please note that the category 'Homerton healthcare staff' includes staff working as 'agency' staff at Homerton. The 'Homerton non-healthcare staff' include staff providing services to Homerton as part of a contracted service. The 'Carer' category includes 'informal' caring arrangements as well as staff in nursing homes. The 'Institutional' category denotes where an organisation's systems have been implicated in the incident e.g. failed discharge planning.

The safeguarding team will use this analysis in a variety of ways during 2014/2015, including improving the Datix incident reporting system and in developing case studies used in safeguarding adult training and competency assessments.

Priorities for action 2014/2015:
Improving adult safeguarding processes and outcomes through learning from incidents and referrals

- Review and develop the Datix reporting system by devising a bespoke section for 'Safeguarding'. This will support triggers for safeguarding action such as DoLS applications, capacity assessments, safeguarding referrals and CQC notifications. An improved system will also underpin more timely and accurate analysis of adult safeguarding incidents and referrals.
- Devise a system to capture all safeguarding referrals consistently. The system will support the objective of analysing the appropriateness and quality of referrals and the outcomes, including the learning from each referral.

(These improvements will feed into the priority to improve the competence and confidence of the workforce in acting on adult safeguarding issues).

E: Addressing issues of diversity
F: People who use services are informed about safeguarding adults and empowered within the organisation's responses to it

A key member of the adult safeguarding team, the lead nurse for vulnerable adults, pioneered and led the work undertaken at Homerton on the equality objectives. In particular, she led participation in the MIND/Rethink 'Time to Change' campaign to tackle stigma and discrimination by changing attitudes and behaviour towards mental health problems. The adult safeguarding team is committed to continuing this participation in the wider work on Equality and Diversity.

'Respectful' and 'Personal' are two of the four core Homerton values and involve:
'providing services that meet the diverse needs of our communities' and
'actively listening to and involving patients and service users in decisions about their care';

Homerton provides information to adults at risk and their families about safeguarding adults in written and pictorial formats

Priorities for action 2014/2015:
Using the Homerton values 'personal' and 'respectful' to improve adult safeguarding practice

- Improve data capture on issues of diversity to enable analysis of incidents and referrals against the protected characteristics in the Equality Act 2010
- Revise and refresh Homerton's participation in joint working with East London NHS Foundation Trust to ensure that the physical/medical health needs of mental health patients are met effectively and well managed. This work will also involve collaboration with the Homerton Psychological Medicine service.
- Develop a plan to improve joint working between adult safeguarding and experts (including patient and service users) in Learning Disability, Dementia and End of Life care.

Develop a plan to capture information and views of the experience of patients and service users involved in adult safeguarding.

2.5 East London NHS Foundation Trust

Overview

The Trust continues to ensure that safeguarding adults concerns maintain a high profile across all its services. This includes a continued active role in the work of the London Borough of Hackney Safeguarding Adults Board. The Locality Director or Associate Director for Safeguarding Adults regularly attends the meetings and ensures all requests are actioned.

Key developments for 2014/15

The Safeguarding Adults Self Assessment Framework report, devised by NHS England, was adopted in **Tower Hamlets** for all partner organisations to complete.

The Report was to be RAG rated according to the following guidelines.

GREEN rating – the organisation meets the requirement consistently across the organisation.
AMBER rating – the requirement is met in part; there may be pockets of excellence and areas for improvement.
RED rating - the organisation does not meet this requirement.

The Trust assessed itself to have 20 Green and 4 Amber ratings, with no identified Red ratings. The four Amber ratings, outlined below, will be added to the Trust Annual Report Workplan with the aim of achieving Green rating for all 24 standards by the end of 2014/15.

B3 All services demonstrate compliance with the Mental Capacity Act
C2 Supervision policy and practice routinely address staff safeguarding responsibilities
F3 Provision of written information and guidance by the Trust for Adults at Risk within the services and their involved family members
F4 Feedback is sought from adults at risk, who have been the subject of safeguarding support and/or investigation, about their experience of the outcome.

Safeguarding activity/incidents

There have been no Serious Case Reviews or Domestic Homicide Reviews involving Trust service users during this year.

Training

The Trust has consistently achieved over 80% compliance for staff across all Trust services attending Safeguarding adults training at Level 1. It is anticipated for next year that the Trust will be able to report on Level 2 course for staff with designated roles in implementing procedures.

2.6 City and Hackney Clinical Commissioning Group

Overview

NHS City and Hackney Clinical Commissioning Group (CCG) is a newer NHS organisation. CCGs are led by GPs, allowing them to be better placed to assess, understand and meet the health needs of their patients, ensuring effective and accessible healthcare for all. City and Hackney CCG is made up of 44 GP practices. The CCG is responsible for:

- Understanding the health needs of the population
- Facilitating the design and redesign of services
- Buying services
- Measuring the impact of services and how well they are provided.

City and Hackney CCG is committed to commissioning patient care that is high-quality, effective and safe. As a major commissioner of local health services, the CCG recognises its responsibilities to ensure that the organisations it commissions have effective safeguarding systems in place and that these systems are monitored appropriately. The Chair of the CCG Board has overarching responsibility for all Safeguarding across the CCG and there is a local GP Clinical Lead for Adult Safeguarding.

Safeguarding Activity

Safeguarding Adults has been a high priority for the CCG during 2013-14 and achievements during the year have included:

- Publication of the CCG's Safeguarding Adults Policy – comprehensively. outlining provider organisations responsibilities around Adult Safeguarding
- Providing training in primary care for GPs and nurses on Safeguarding Adults, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS).
- Securing extra funding from NHS England to allow for more resources around training in MCA) and DOLS – this money will used during 2014-15 to fund further training in primary care for both clinician and non-clinical staff members, the London Borough of Hackney and the Safeguarding Adults Board itself.
- Being fully engaged with the local Safeguarding Adults Board and Health and Wellbeing boards.
- Working closely with partners in the Safeguarding Adults Board to help prepare for the Care Act introduction in April 2015.
- 24 safeguarding alerts were made from Primary Health staff between March 2013 and April 2014. 14 of these alerts were then fully investigated under the LBH safeguarding procedure. Of the 14 investigations 2 were substantiated, 3 partially substantiated, 4 not substantiated and 5 inconclusive.

The CCG is looking forwards to continuing working with partners during 2014-15 to prepare for the statutory changes coming into effect with the introduction of the Care Bill in 2015.

2.7 Care Quality Commission (CQC)

Overview

CQC is a committed member of CHSAB and supports the Board's strategy for prevention and gives advice and support in adults at risk cases as required. CQC has developed a safeguarding protocol for its staff in February 2013 which describes their role in safeguarding children and adults. The underpinning priorities are:

- focus on quality and act swiftly to eliminate poor quality care;
- making sure that care is centred on people's needs and protect their rights.

Our local CQC regional manager attends the Board promoting CQC's role, sharing regulatory information and contributing to partnership working. CQC made one direct safeguarding alert referrals in 2013/14. The CQC, has adopted a five pillar question system of review which includes: is the service safe, effective, caring, well led and responsive to peoples needs.

2.8 Barts Health

Overview

This section details the work that has been undertaken at Barts Health to ensure that the people in our care, who are at risk of abuse or neglect are protected and to provide assurance that we are compliant with the Care Quality Commission (CQC), essential standards for Safeguarding Adults.

It includes

- An update on the team
- A summary of key work undertaken in the last year
- An outline of work planned for 2014 – 2015

Staff and Team Developments

This year has been a time of transition and development for the Safeguarding team. We have now fully recruited to the team which is made up of a lead post Head of Safeguarding Adults; a Safeguarding Co-ordinator, a Lead Nurse for Learning Disabilities and an appointment made to lead in mental health, the Mental Capacity Act; Deprivation of Liberty Safeguards and the PREVENT Strategy. The team also has a designated administrator.

The learning disabilities post is a new post, developed in response to feedback from carers regarding the need to improve the support offered to people with learning disabilities who are admitted to hospital.

The appointment of a lead for MHA/MCA/DoLS occurred before the Cheshire West judgment but will support the new and increased workload deriving from that judgment as well as the Trust-wide training needs that follow from it. Since the appointment, the Trust's MHA arrangements have been consolidated, through the

agreement of an SLA for MHA administration with each of our partner MH Trusts. The post holder also has responsibility for leading a work stream relating to the use of restraint in clinical settings.

Training

As planned we have improved the staff training compliance this year.

Overall training compliance figures for Barts Health are
Level 1 96%
Level 2 93%

Training compliance across the hospital sites is set out below

Level	WXH	NUH	RLH	SBH	LCH	MEH
1	**94%**	**94%**	**94%**	**97%**	**98%**	**97%**
2	**92%**	**94%**	**90%**	**95%**	**95%**	**96%**

The statutory training has been supplemented with bespoke training provided to the nursing preceptorship programme, sessions for student nurses and to clinical teams in trauma, accident and emergency and cardiac services.

Key achievements 2013 – 2014

- **Developing effective information systems**

A safeguarding adults' tracker database has been developed to support the safeguarding work. The database provides regular information to Trust Directors and a point of reference for the safeguarding team to ensure timely progress of investigations. The database will enable thematic analysis of safeguarding concerns raised by Borough, hospital and ward so that trends can be identified, concerns addressed and training needs met.

Partnership Working

- With other partners, Barts Health has adopted the Safeguarding Adults at Risk Audit to be monitored by NHS England. The audit will enable us to identify and share good practice as well as identify priorities for improvement and inform our annual work plan.

- The membership of the internal committees that support the safeguarding agenda at the Trust has been extended to include the Borough Safeguarding Service Managers and Commissioners in order to improve communication and facilitate greater partnership working.

- The policies and processes in place that will support compliance with the mental capacity act and deprivation of liberty safeguards are being developed.

Safeguarding activity

The total number of safeguarding alerts raised last year was 126. These are broken down by service in the table below. The highest number of alerts was raised in our

Emergency Care and Acute Medicine Group. This is the largest service group in the Trust and incorporates stroke, older people's services and accident and emergency.

Clinical Academic Group	Number of Safeguarding Alerts Raised
Cardiovascular	3
Community Health Services	2
Chief Operating Officer	1
Clinical Support Services	6
Emergency Care/Acute Medicine	106
Nursing Quality Governance	1
Surgery	7

CQC Inspection and Safeguarding

The Care Quality Commission undertook an extensive inspection of services across Barts health throughout November 2013. One key recommendation of high importance to the safeguarding agenda is that the Trust should improve in how it listens to staff and responds to their concerns. The key actions are to:

- Reaffirm that bullying and harassment has no place in the organisation
- Provide an anonymous web based tool for staff to use to contact a director personally for help, advice or to raise concerns.
- Extend the staff partnership forum to improve engagement and hear staff views from across the Trust.
- Commission independent research to investigate and understands staff experiences in the workplace.
- Promote a safety culture in particular the visibility of managers. This includes the appointment of Hospital Director, Hospital Matron and medical equivalent working in alignment with CAG leads; re launch first Friday with greater involvement of executives in the work of clinical areas and increased executive visibility on all sites at the weekends.

Plans for 2014 - 2015

- Training for the PREVENT initiative will be commenced in the Emergency Departments. The safeguarding children team will be involved in the organisational assessment process for PREVENT to ensure an integrated approach.
- The Statutory training books are to be developed further to include information about human trafficking, Female Genital Mutilation and more detailed information about learning disabilities and the PREVENT agenda.
- The procedures in place to ensure timely and effective multi-agency working with the 3 main Boroughs are being clarified to ensure that expectations and timeframes are understood and met.

Plans for 2014 – 2015 cont'd

- Work priorities will be clarified and agreed following a review of the evidence available to support achievement of the standards outlined in the Safeguarding Adults Audit Tool.
- To increase the involvement of clinical services in the integrated safeguarding assurance committee to receive regular assurance reports from them.
- To agree a sector wide pressure ulcer reporting pathway in relation to safeguarding, through the CCGs and Borough safeguarding teams.
- To agree an internal standard operating procedure for contributing to Serious Case and Domestic Homicide Reviews.
- To further develop the internal safeguarding tracker to enable more detailed data capture and analysis.