



Annual Report 2015 - 2016

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



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Message from the Independent Chair



I am very pleased to introduce the Annual Report for the City and Hackney Safeguarding Adults Board 2015/16, covering the first year of operation under the Care Act 2014. This is also my first year as the Independent Chair and I am very grateful to all partners for their welcome to me in this role, and their ongoing support. The partnership has grown, developed and strengthened over this year, as is reflected in the Annual Report.

I think that, as a Safeguarding Adults Board, we have responded to the new demands of statutory status very positively. We have established new sub-groups to ensure that challenges of the new duties can be met, such as undertaking Safeguarding Adults Reviews. This sub-group has been working very well, overseeing a range of initiatives and responses described in the body of this report. Additionally, progress has been made in terms of ensuring that the work of the Board is accountable to local people, through the recently established Communication & Engagement sub-group. I am very committed to the work of the Board being informed by the views of the communities we serve so I am pleased that we were able to speak with so many people through our public consultation events and the meetings attended to talk about the Board's draft Safeguarding Adults Strategy. We were able to hear their views and include their ideas in the work to revise the strategy and plans. I know that safeguarding remains a word that most people don't understand and it is our collective responsibility to make it comprehensible, and to ensure that safeguarding services can be accessible, so that those citizens who most need our support can access it.

We have also addressed new responsibilities included under the safeguarding part of the Care Act, for example to safeguard and work with people who self-neglect or hoard. This has been a specific priority this year and we have developed and piloted new multi-agency ways of working to help support people better. This is an area where we still have more to learn from the outcomes of Safeguarding Adults Reviews on how to improve our approach and work more effectively.

This Report is important because it shows what the Board aimed to achieve on behalf of the residents of the City and Hackney during 2015/16, both as a partnership and through the work of its participating partners. It shows that we have an ambitious agenda and what we have been able to achieve, as well as those elements that we still need to do.

Cont.

The Report provides a picture of who is safeguarded in City and Hackney, in what circumstance and why. This helps us to know what we should be focussing on for the future and so the Report includes our next Strategic Plan priorities for 2016/17.

I am very mindful of the pressures on partners in terms of resources and capacity so want to thank all partners and those who have engaged in the work of the Board, for their time and effort. In particular, I would like to thank Paul Griffiths as the Board Manager and Jayde Maynard as the Business Support Officer, who started in 2015, for their work, which has made such a significant impact in helping the Board deliver its aims and objectives.

I know that there is a great deal that we need and want to do to reduce the risks of abuse and neglect in our communities and support people who are most vulnerable to these risks. This is a journey that we are all making together, and I look forward to continuing to chair the partnership in the next year to continue on this journey.

Dr Adi Cooper, OBE

About the City & Hackney Safeguarding Adults Board

Who we are

The City & Hackney Safeguarding Adults Board (CHSAB) is a partnership of statutory and non-statutory organisations, representing health, care and support providers and the people who use those services across the City of London and the London Borough of Hackney.

The work of the Board is driven by its vision that in the City and Hackney:

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 main objective for the Board, to achieve this vision, is to assure itself that effective local adult safeguarding arrangements are in place and that all partners act to help and protect people with care and support needs in the City and Hackney.

The CHSAB has three core duties under the Care Act 2014 that it must fulfil in achieving its main objective:

- develop and publish a Strategic Plan setting out how it will meet its objective and how its partners will contribute to this
- publish an Annual Report detailing how effective their work has been
- commission Safeguarding Adults Reviews (SARs) for any cases that meet the criteria for these reviews

This Annual Report give details of our Strategic Plans for 2015/16 and 2016/17, sets out how effective the CHSAB has been over the 2015/16 year, provides detail on the SARs that it has commissioned, and describes how its partners have contributed to the work of the Board to promote effective adult safeguarding.

Our Principles

The CHSAB had proposed that four local principles should underpin all its work to achieve its main objective in the 2015/16 year. These principles have been:



These principles informed and structured our Five Year Strategy and Annual Plan. In the 2015/16 year we consulted with people living in the City and Hackney about these principles and our Strategy. You can find more information about this consultation and what people told us later in this report.

The principles of the CHSAB complement and promote the six statutory principles of Adult Safeguarding set out in statutory guidance:

- | | |
|------------------------|-----------------------|
| Empowerment | Protection |
| Prevention | Partnership |
| Proportionality | Accountability |

Governance

The CHSAB partnership consists of representation from:

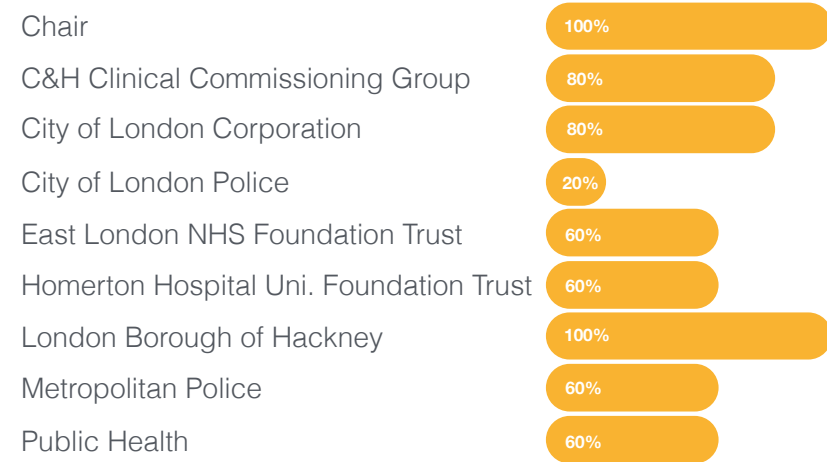
- City of London Corporation
- London Borough of Hackney
- City and Hackney Clinical Commissioning Group
- East London NHS Foundation Trust
- Homerton University Hospital NHS Foundation Trust
- City & Hackney Older People Reference Group
- Metropolitan Police Service
- London Fire Brigade
- London Ambulance Service
- Care Quality Commission
- Barts Health NHS Trust
- National Probation Service
- Hackney Healthwatch
- City of London Healthwatch
- Hackney CVS
- City of London Police

Dr Adi Cooper OBE became the Board's new independent chair in June 2015, taking over from Dr Fran Pearson who was the previous independent chair.

The full CHSAB partnership met on a quarterly basis during the 2015/16 year, including at a special Development ½ Day in February 2016. Partners' attendance at these sessions was:



The work of the CHSAB is supported by the CHSAB Executive Group. This Group consists of senior managers from some of the key partner agencies of the Board. The Executive Group meets regularly in between the full CHSAB's quarterly sessions and is also chaired by Dr Cooper. Members of the Executive Group chair the CHSAB's sub-groups. Partner attendance at these Executive Group sessions was:



You can find more details regarding CHSAB meeting attendance in Appendix 1.

The City of London Adult Safeguarding Sub-Committee consists specifically of agencies working in the Square Mile. The Sub-Committee provides a clear recognition of and focus on safeguarding arrangements in the City, enables communication with the full CHSAB and is a means of developing a City-focused adult safeguarding in line with the CHSAB's priorities. It was agreed in 2015/16 that Dr Cooper would assume the chairship of the Sub-Committee in the 2016/17 year.

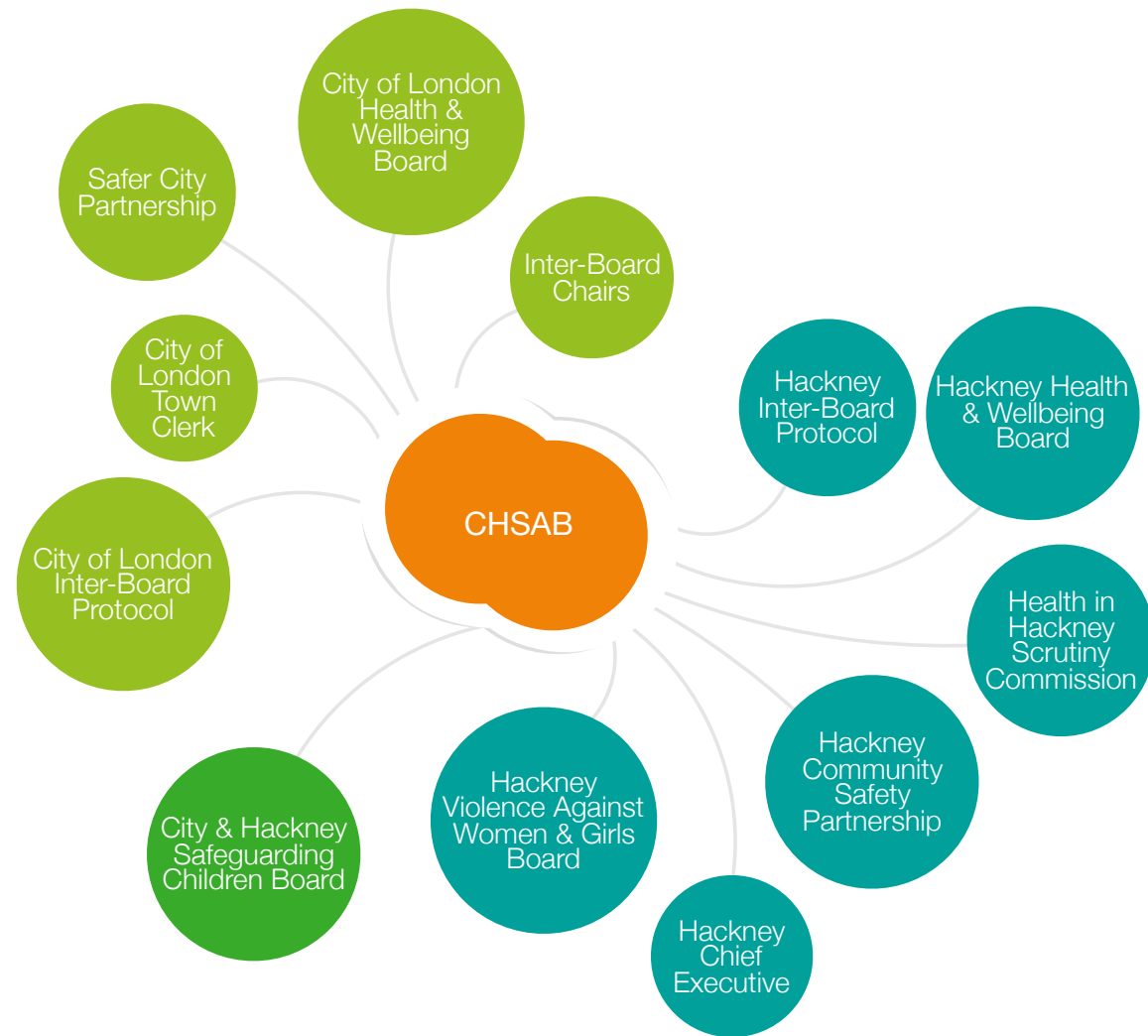
The CHSAB has established a number of multi-agency sub-groups to help it deliver on its objective and annual priorities. These are considered in more detail the '2015-2016 - What We Have Done' section below.

Our overall structure is illustrated below:



Our Strategic Links

The CHSAB has links with the following partnerships, agents and boards also working with communities in the City of London and Hackney as described in the figure below. We have continued to develop our relationships with these local strategic bodies. This enables the Board to help ensure that local arrangements are working to support people with care and support needs from the experiences or risk of abuse and neglect.



This year we have worked to ensure that our new annual strategic plan promotes joint-working with the City & Hackney Safeguarding Children Board.

Case Study

Making a difference: working in partnership

Mrs H is an 84 year old woman with mild dementia who lived with the two adult sons of her deceased partner. The sons owned the home. One of the sons, Mr D, is known to mental health services, the other son, Mr J, was alleged by Mrs H to physically, financially and emotionally abuse her. Mrs H appeared scared of Mr J and Mr J would not allow the social worker or other professionals into the house. It was hard for the social worker to contact Mrs H but she met her several times at the GP surgery and Mrs H was very upset about her situation, crying and holding onto the social worker. However, she said that she did not want the police to be informed and did not feel able to go to the alternative accommodation that the social worker offered. Mrs H was assessed as having capacity to make a decision about where she lived. This situation continued for several months and a multi-agency concern was expressed at the community MARAC about the level of risk to Mrs H. As a result of this risk assessment, a multi-agency decision was made to override Mrs H's wish for the police not to be contacted and a plan was made that the social worker would meet with Mrs H at the GP surgery and attempt to persuade her to move immediately to Housing with Care accommodation. At the same time, the police would go to the home and arrest Mr J. Mrs H agreed to move and was assisted to do so by the social worker. It is reported by the social worker that the move has been successful. Mr J was arrested and released on bail. He has not approached Mrs H subsequently.

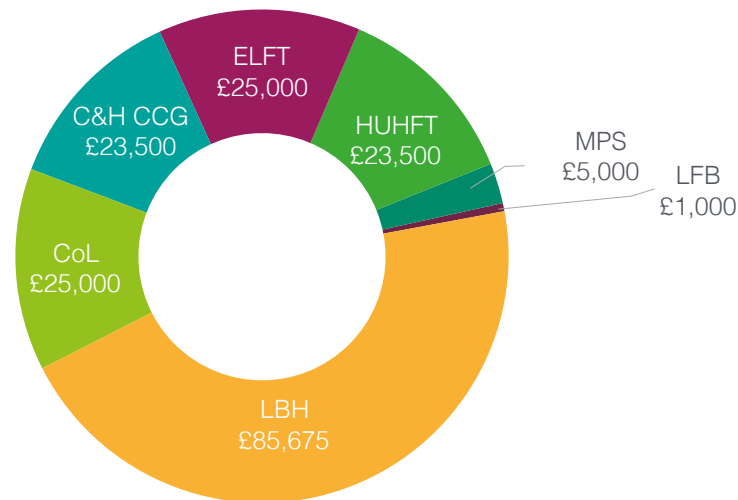
This case provides an example of the difficulties of decision making that is based on Making Safeguarding Personal principles when the adult at risk has capacity to make decisions about their welfare and does not wish for any intervention but there is a significant level of risk to the person. In this case, the social worker worked with Mrs H for some time to build rapport and try to persuade her to move and agree to police intervention. However, the multi-agency consensus was that at a certain point an intervention was required that had not been agreed to by Mrs H. This situation was further complicated by the difficulty in contacting Mrs H who did not have access to a 'phone. There was a positive outcome to this case as Mrs H has identified as being happy to have moved and risk of abuse have been minimised. The positive outcomes were achieved even though actions were taken that Mrs H had not consented to and Mrs H was protected from further abuse.

Financial Arrangements

Funding

This year the CHSAB received total funding of £188,675, detailed in the figure below. Five key statutory agencies had agreed to contribute financially to the CHSAB's operating budget before the year began. The Homerton University Hospital Foundation Trust and the City and Hackney Clinical Commissioning Group each contributed £23,500 (12.5%). The East London NHS Foundation Trust and the City of London Corporation both contributed £25,000 (13.2%). The London Borough of Hackney was the major financial contributor to the CHSAB, providing £85,675 (45.4%). This ensured that the Board was prepared to meet its new statutory requirements and enabled the formation of a new CHSAB Business Support Team to support the partnership to meet its obligations.

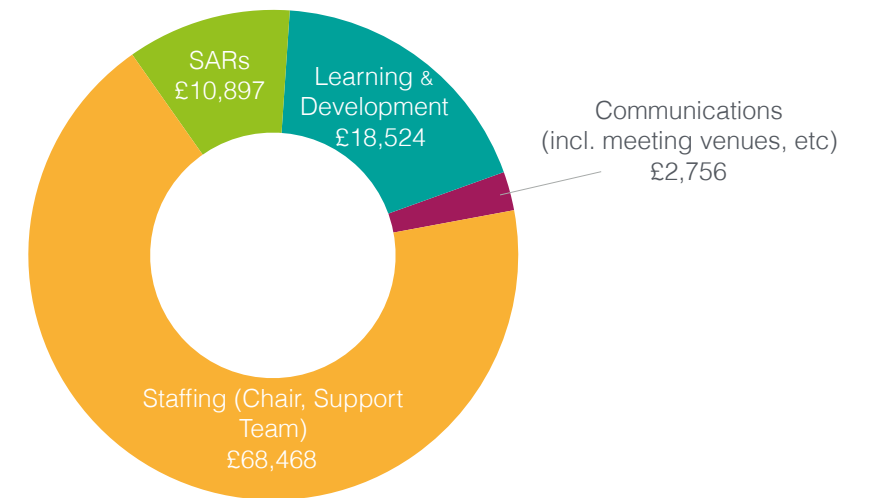
In the last quarter of the 2015/16 we were pleased to receive further contributions from the London Fire Service (£1,000, 0.5%) and the London Metropolitan Police Service (£5,000, 2.7%). Other partners have contributed with their time and commitment to the Board's work and by providing access to resources such as meeting venues, conferences, etc.



We recognise that such a funding arrangement does not necessarily reflect the multi-agency constitution of the Board or the partnership working that is required of effective adult safeguarding arrangements across our communities. This can be better promoted and secured by financial contributions from across the partnership, so we will be asking more partners to contribute financially for the 2016-2017 year.


Expenditure

The figure below indicates 2015/16 CHSAB expenditure. Staffing costs, comprising of the independent chair and the CHSAB Business Support Team, make up the majority of expenditure, followed the Board's funding of multi-agency training opportunities and then the costs incurred from SARs that have been instigated this year. Overall, there was an underspend for this financial year, largely due to the CHSAB Business Support Team not being recruited and in post until quarter 3 of the financial year.



2015 - 2016: What we have done

Safeguarding Adults Boards have operated on a statutory footing for the first time under the Care Act 2014 from 1 April 2015. Building on its previous preparations for the incoming legislation, this year the CHSAB undertook significant work to ensure that it fulfilled its statutory responsibilities and established a firm platform for continuing to do so. This work has included:

-  Reviewing and strengthening the Board's sub-groups
-  Commissioning Safeguarding Adults Reviews
-  Supporting the partnership by establishing the CHSAB Business Support Team
-  Providing multi-agency learning & development opportunities
-  Consulting on our 5 Year Strategy
-  Partners undertaking self-audits to provide assurance to themselves and the CHSAB of the effectiveness of local adult arrangements
-  Delivering on our annual strategic plan for 2015/16
-  Developing our next annual strategic plan for 2016/17

Sub-groups

This year the roles and composition of the CHSAB sub-groups were consolidated to ensure that they will continue to support the work of the Board and deliver on its annual plans. Each sub-group now has renewed Terms of Reference in place, which will be reviewed regularly to ensure that they support the CHSAB's strategic priorities. The sub-groups benefit from multi-agency representation with staff from statutory and non-statutory agencies attending and contributing to the work. We are moving to better involve people who use services or their representatives in the work of the sub-groups. For example, Hackney CVS representatives attend the SAR sub-group while the Communication & Engagement sub-group will benefit from user and advocacy representation.

The Quality Assurance sub-group has worked with partners to develop a general adult safeguarding dataset, which will report regularly to the CHSAB going forward. This will enable the partnership to be informed of local adult safeguarding activity and better placed to identify trends and patterns that the intelligence may highlight.

The Training & Development sub-group established a programme of multi-agency training opportunities for statutory and non-statutory partners to take advantage of during the year. More details of this are given below. Towards the end of the year the sub-group was already in the process of developing a full multi-agency training programme for 2016/17, again to be open to statutory and non-statutory partners, as well as care and support and housing providers working in Hackney and the City of London.

The re-formation of the Communication & Engagement sub-group took stock of the community and voluntary sector events that were a cornerstone of the CHSAB's strategic consultation (see below). These listening opportunities helped to establish the basis for a more active, effective manner for the CHSAB and community services to work together and exchange key messages regarding the Board's work and people's experience of local adult safeguarding arrangements. Building on this success, Hackney CVS has been developing a City & Hackney Community Engagement Forum that will feed directly into the Communication & Engagement sub-group. Going forward the sub-group will oversee a new Communication Strategy for the Board.

The SAR sub-group is the primary mechanism by which the CHSAB exercises its statutory duty to arrange a SAR when someone with care and support needs within its locality dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively together to protect the person. The sub-group is well established and during the course of the year has considered a number of SAR referrals and overseen the commissioning of several Reviews. The sub-group made recommendations to the CHSAB Chair on which cases required a statutory Review and which cases warranted an alternative approach to discerning practice learning. More details on these are given in the next section. The sub-group will monitor and report to the CHSAB on the development and implementation of multi-agency action plans that may flow from SARs to ensure that the learning from the Reviews has a meaningful and lasting impact on how services work with adults with care and support needs.

The CHSAB has been mindful of ensuring that the City of London partners are equally present and recognised in the work of the partnership. There is City of London representation across the sub-groups, the City of London Assistant Director for People chairs the SAR sub-group and this is also attended by the City of London Adult Social Care Service Manager. The Service Manager for the City of London Healthwatch is now a member of the Communication & Engagement sub-group.



Safeguarding Adults Reviews

The SAR sub-group received six referrals for consideration as SARs during the course of 2015/16. Following evaluation of these against the statutory requirements and in line with the CHSAB's SAR Protocol, the CHSAB instigated three new SARs this year and at year-end was considering another referred case. One SAR that the Board had commissioned in the previous year has continued to run its course throughout 2015/16 year. None of the four SARs completed their processes before the end of March 2016.

The sub-group advised that while two cases did not meet the statutory criteria for SARs, single agency Individual Practice Reviews (IPRs) would instead be an effective, proportionate approach for discerning any learning that could be applied to future, safe practice. The London Borough of Hackney commissioned an independent reviewer to undertake these Reviews. The SAR sub-group will be monitoring the improvement actions undertaken in response to these IPRs.

The continuing SAR concerns Mrs A and Mr B, who were residents in a supported housing with care complex. There were concerns that Mr B posed a fire risk to the other residents and that he allegedly sexually assaulted Mrs A in her flat. The Review has been necessarily drawn out, being mindful both of working with the families of those involved and that it is running in parallel with other reviews or investigations. The CHSAB followed the Social Care Institute for Excellence's *Learning Together* model for this SAR.

The first SAR to be commissioned this year involves the case of Mr BC and it will complete and report to the CHSAB early in the 2016/17 year. Mr BC was an older person living in a sheltered housing scheme who died in a fire at his home in 2014. He was a heavy smoker who routinely drank large amounts of alcohol and was using a number of services at the time of his death. On course to conclude within six months and by the end of this reporting year, the process was extended slightly into the next reporting year so as to ensure that all the agencies involved would have sufficient time to consider and accept the report's findings. A multi-agency meeting was pre-arranged for early in April 2016 to consider the draft report's findings and to plan agencies' improvement actions. This SAR adopted a more traditional approach set out by other SARs and Serious Case Reviews, establishing a SAR Panel, with an independent Panel Chair and an independent lead reviewer, which commissioned Individual Management Reports (IMRs) and further evidence from the agencies involved.

During the course of this Review, the Panel advised the CHSAB Chair that it was necessary to seek from the housing provider involved further assurance, beyond and complementary to the scope of the SAR, that it had taken sufficient action to reduce the likelihood of serious injury due to fire to vulnerable individuals in their properties. The provider gave this assurance satisfactorily before the SAR completed.



The second SAR commissioned this year concerns Mr GH, who was also an older person living in a sheltered housing scheme. Mr GH passed away in 2015 while experiencing a number of health issues and using a number of services. This SAR is following the same methodology as is described above. For this second commission the CHSAB funded specific IMR training for the agencies and SAR panel members involved, to help ensure that the process was well supported to deliver effective evidence-based learning. This is an example of how the CHSAB is continually working to evaluate and develop its practices.

The third SAR commissioned this year concerns Mrs Y, who passed away in 2015 while there were concerns regarding how agencies may have worked with Mrs Y and her family. For this Review the CHSAB has developed a different approach which is proportionate to the individual needs of the case. It is anticipated that this and the other three SARs will complete and deliver overview reports in the 2016/17 year. Next year's CHSAB Annual Report, therefore, will provide more detail on these Reviews, their findings, the findings the CHSAB has by then implemented and which findings, if any, it has decided not to implement.

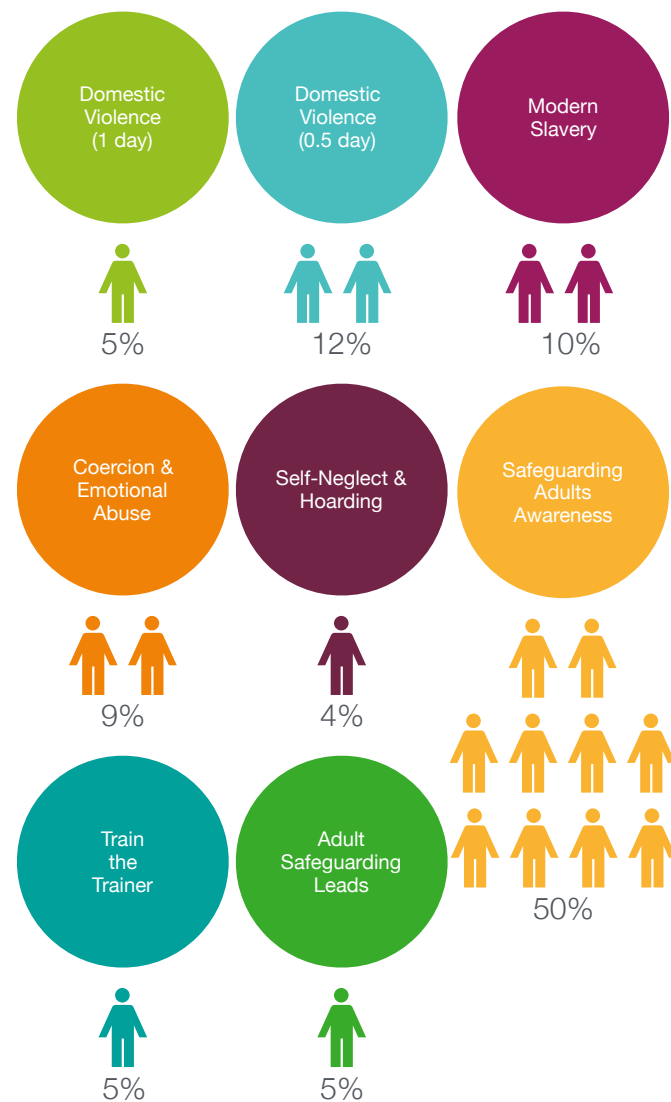
Supporting the CHSAB

This year we successfully recruited and established a dedicated CHSAB Business Support Team comprising of a full-time Board Manager and a full-time Business Support Officer. The Team have brought management focus and administrative support to the work of the CHSAB, its strategic work, the sub-group structure, the public consultation, partners' ongoing contributions, and to the delivery of Safeguarding Adults Reviews and Learning & Development opportunities.

Multi-agency Learning & Development

In the latter half of the year the CHSAB commissioned a range of multi-agency adult safeguarding training opportunities for all statutory and non-statutory partners. Delivering such training enabled the CHSAB to promote competence in adult safeguarding across the partnership and fulfil a key element of the Board's annual strategic plan. Various sessions were held either at the Hackney Service Centre, in the City of London or at the Hackney CVS, enabling **528** people to benefit from this training as indicated in the figure opposite.

The CHSAB also welcomed Detective Chief Inspector Phil Brewer to a full Board meeting in March 2016 to deliver an informative session on Modern Slavery and Human Trafficking.



Public consultation

We ran a significant public consultation from 23 October 2015 to 15 January 2016 to involve the community and statutory and non-statutory providers, as well as Hackney Healthwatch and City of London Healthwatch, in the development of the Board's Five Year strategy. This strategy will lead the development of the CHSAB's annual strategic plans over the coming years.

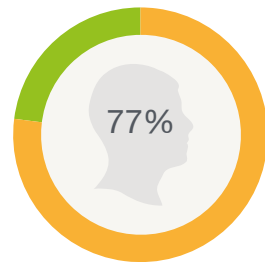
The consultation set out the four key **principles** that the CHSAB had suggested and five strategic **aims** that the CHSAB should look to achieve in realising its main objective. We asked people for their views and suggestions about the principles and aims and what action they thought the CHSAB should take. We sought to engage with people through a variety of media, which included:

- A dedicated Citizen Space consultation webpage an online, printable and easy read version questionnaires
- Distribution of hard copy questionnaires
- Articles in Hackney Today publicising the consultation
- Staff members received details of the consultation (via email, intranet, Hackney Staff Headlines, Hackney Staff Newsflash, Staff Hackney Adult Safeguarding newsletter, manager cascade, etc)
- #OurDay tweets
- Articles for inclusion in agencies' own newsletters (e.g. the Learning Trust, Interlink, Hackney Healthwatch, City of London Healthwatch)
- Community agencies were approached and sent information directly
- Nearly 50 specific agencies and forums approached to help publicise the consultation
- Attending existing forums and specifically arranged events (with the welcome support of Hackney CVS) to engage providers and members of the community
- Attending *The Big Do* for people with learning disabilities
- Presenting at the Older People Reference Group's annual conference
- Presenting and workshopping at the City of London's *Safer in the City* event

The four key principles are set out earlier in the report. The five strategic aims we asked people about were:

1. **“Prevention** – people at risk of abuse or neglect are able to protect themselves from harm and help each other.”
2. **“Choice and Empowerment** – people make informed decisions and choices, and manage the risks they take.”
3. **“Listening and Engaging** – using the views and experiences of people who use services, patients, carers and staff to improve and develop services across the partnership.”
4. **“Standards and Accountability** – people at risk of abuse or neglect using care and support agencies get safe and appropriate services that keep them safe and respect their dignity at all times.”
5. **“Access and Protection** – City and Hackney residents have fair and equitable access to all services across the safeguarding partnership.”

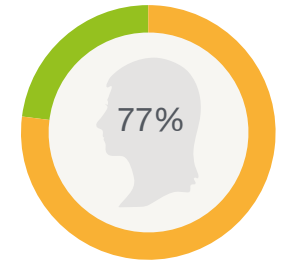
A detailed report on this consultation is available on the CHSAB’s webpages. However, below we set out the key messages and main findings.



Overall, 77% of people who responded in the consultation thought that the principles suggested were the right ones for the Board. We amended the wording of some principles based on the instrumental responses received. Going into 2016/17, the **principles** that underpin our work will now be:



Similarly, 77% of respondents thought that the suggested strategic **aims** were right for the Board. We have used this understanding to develop our annual priorities for our 2016/17 strategic plan. You can read more about this later in this report.



We identified the following **key messages** below, both from the surveys received and from the people who contributed to the face-to-face consultation events and forums.

The CHSAB has taken these key messages into account when devising its 2016/17 priorities and annual plan (see later section).





CHSAB Partner Self-Audits

In October to December 2015 all CHSAB partners were asked to complete a Self-Audit that enabled them to evaluate their ongoing adult safeguarding activity and share this with the Board. Partners identified areas where they considered that they were performing well and areas where they felt they needed to improve. Compiling the audits led the CHSAB to establish that there were shared thematic issues across the partnership and the CHSAB has used these to develop and inform its priorities for the coming year. The main thematic issues are set out below:



Case Study

Making a difference: care concerns allegation

The victim is 65 years old and confined to their bed. Police attended at the request of Adult Social Care, who was present at the address. The victim had been in receipt of care from a care agency since January 2013 but had been dissatisfied with the level of basic care provided. Previous complaints made by the victim had not been actioned or taken seriously by the agency.

The victim had documented incidents of poor practice in a diary which was missing. A multi-agency investigation commenced. A joint visit to the victim was completed with police, scenes of crime officer and Adult Social Care to listen to the victim's account and to collect evidence of the condition of the property.

No criminal offences were identified but the victim's needs were reviewed. New sheltered accommodation was found with the victim and new carers have been appointed to provide them with additional care and support.

This is another example of how partnership work helped to manage safeguarding risks to vulnerable adults.

2015/16 Annual Plan

The following pages set out how the CHSAB progressed with its strategic objectives for this year.

All of our learning will be shared learning

We said that:
By the end of the year systems for feeding back issues to the CHSAB would be established and that the CHSAB would become a forum for real debate about current and emerging safeguarding issues

What we did:

- Delivered Safeguard Leads training for the VCS sector
- Piloted a Self Neglect Protocol and Community MARAC
- Commissioned SARs in line with cases met the statutory criteria
- Developed SAR Referral Guidance for partners and the community
- Fire prevention workshops delivered by LFB
- Linked training & development to Domestic Violence work through the LBH's Interim DV Transformation Manager attending the subgroup
- Commissioned multi-agency learning & development opportunities
- Held a CHSAB Development Session, informed by partners' self-audits
- Consulted widely on the CHSAB's strategic aims and principles by engaging with multiple provider, user and community forums, feeding back issues to the CHSAB and development of 2016/17 Plan

We need to:

- Develop a CHSAB website
- Establish a model of user engagement
- Disseminate SAR learning

We will promote a fair and open culture

We said that:
By the end of the year there would be processes whereby the content of complaints about organisational practice can be safely shared are agreed, and that all partner agencies have escalation procedures in place and the SAB has a visible role within these issues

What we did:

- Ensured that partners signed up to new London Multi-Agency policy & procedures
- Supported the work of the LBH Grant Funding Team in readying funding requirements in line with the new multi-agency policy & procedures
- CHSAB chair now chairs the CoL Adult Safeguarding Sub-Committee
- Established the Quality Assurance subgroup
- CHSAB Chair met regularly with LBH Chief Executive and CoL Town Clerk to discuss the CHSAB's work
- Began developing adult safeguard activity/data reporting processes
- Monitored the application of the Deprivation of Liberty Safeguards (DoLS) by CoL and LBH
- Reported on DoLS activity to LBH Scrutiny Committee
- Delivered a comprehensive community consultation on the CHSAB's strategic aims and principles, with an easy read questionnaire as well as attending service user groups, the Big Do for people with learning people disabilities and attending a POHWER session

We need to:

- Develop a CHSAB Escalation Protocol
- Create an easy read Strategic Plan

We will understand the complexity of local safeguard needs

We said that:
By the end of the year hold a partnership workshop to agree any priority areas for focus and how trend data should be captured, agree membership and Chair of regularly meeting QA subgroup, establish process of communication between QA subgroup, the CHSAB and back to front line practice

What we did:

- Established the CHSAB's Quality Assurance subgroup and Chair, as a separate entity to the LBH Quality Assurance Safeguard Board monitoring commissioned services
- The subgroup has piloted data collection requests from CHSAB partners
- Began developing adult safeguard activity/data reporting processes
- Required partners to submit interim adult safeguard data to inform and provide assurance of local safeguarding arrangements
- Held a CHSAB Development Session that helped to measure progress on strategic plan and identify strategic priorities for 2016/17

We need to:

- Establish a CHSAB adult safeguarding dataset
- Establish regular adult safeguarding data and intelligence reporting to the CHSAB

The skill-base of our staff will be continuously improving

We said that:
By the end of the year the CHSAB will have agreed minimum standards for supervision that can be applied across the partnership, involving managers & practitioners are involved in their development; establish practitioners groups, which have a key role in relation to debate and dissemination of the learning from SARs

What we did:

- Established the Training & Development subgroup
- LBH hosted a Making Safeguard Personal (MSP) event, with keynote speakers including the CHSAB Chair and Lyn Romeo, Chief Social Worker for Adults
- CHSAB partners completed adult safeguard self-audits which identified common learning & development needs, e.g. on PREVENT
- Commissioned multi-agency learning & development opportunities on issues such as Self-Neglect & Hoarding, Coercion & Emotional Abuse, Domestic Violence, Adult Safeguarding, Modern Slavery, Domestic Violence
- Commissioned Train the Trainer and Safeguard Leads training for the VCS sector
- CoL and LBH developed systems for capturing adult safeguard and MSP outcomes
- CHSAB strategic consultation to highlighted learning & development needs of the VCS sector
- Developed an online training needs analysis with Hackney CVS for VCS services

We need to:

- Establish minimum supervision standards regarding adult safeguarding
- Develop a Training & Development programme

The outstanding issues from this year's work have informed the development of our priorities and work plan for 2016/17 (see below).

2016 – 2017: What we will do



2016/17 Annual Plan

The following pages set out the annual strategic objectives that we have devised for 2016/17. These objectives have been reviewed against the six statutory principles of adult safeguarding with an emphasis on Making Safeguarding Personal. You can find a more detailed version of the annual plan on the CHSAB website.

We will raise awareness of adult safeguarding and together will learn from experience

What we plan to do:

- CHSAB members engage with local communities and the community and voluntary sector (CVS)
- Develop a model for ongoing user engagement with the CHSAB
- Promote learning from everyday practice.
- Inform the work of the CHSAB with service user feedback about the safeguarding service
- Implement Safeguarding Adults Reviews action plans, and the CHSAB monitor the impact of SAR learning
- Influence services with learning from Serious Case Reviews (SCRs) and Domestic Homicide Reviews (DVHRs)
- Establish an effective CHSAB Communications Strategy

We will promote a fair and open culture

What we plan to do:

- Embed safeguarding into contracts to ensure that quality and safeguarding issues are monitored
- Safeguarding audits provide assurance to the CHSAB of improvements in practice
- Ensure safe and transparent processes for sharing concerns about safeguarding practice are in place

We will understand how effective adult safeguarding is across the communities we work with

What we plan to do:

- Agree, test and review regularly a framework for adult safeguarding activity and trend data, so that emerging risks are identified and local responses influenced accordingly
- Improve understanding of local communities and needs – to be developed with better information
- Work with other Boards to address cross cutting issues, including the 'Think Family' approach

Improve the competency of all those involved in adult safeguarding

What we plan to do:

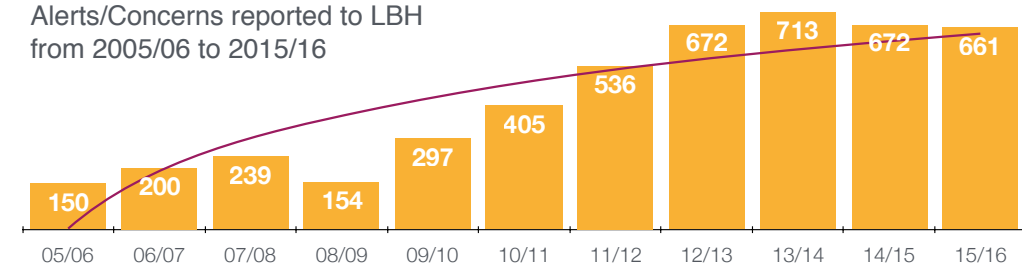
- Establish a multi-agency training programme informed by the CHSAB priorities
- Embed the *Making Safeguarding Personal* approach in practice across the partnership
- Establish agreed minimum standards for supervision of safeguarding practice across the partnership

Adult Safeguarding Activity 2015/16



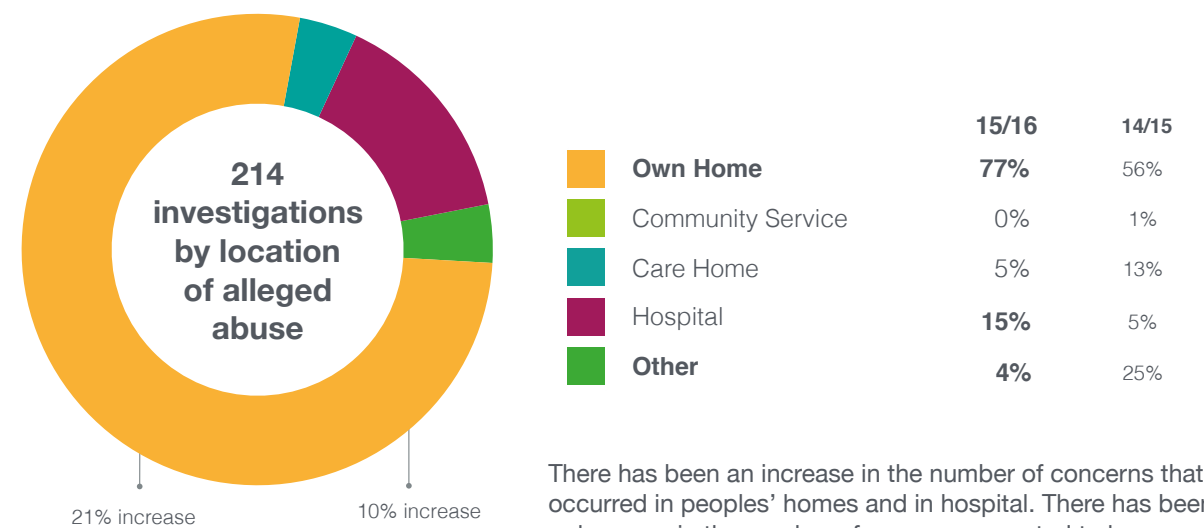
London Borough of Hackney safeguarding data

Alerts/Concerns reported to LBH from 2005/06 to 2015/16

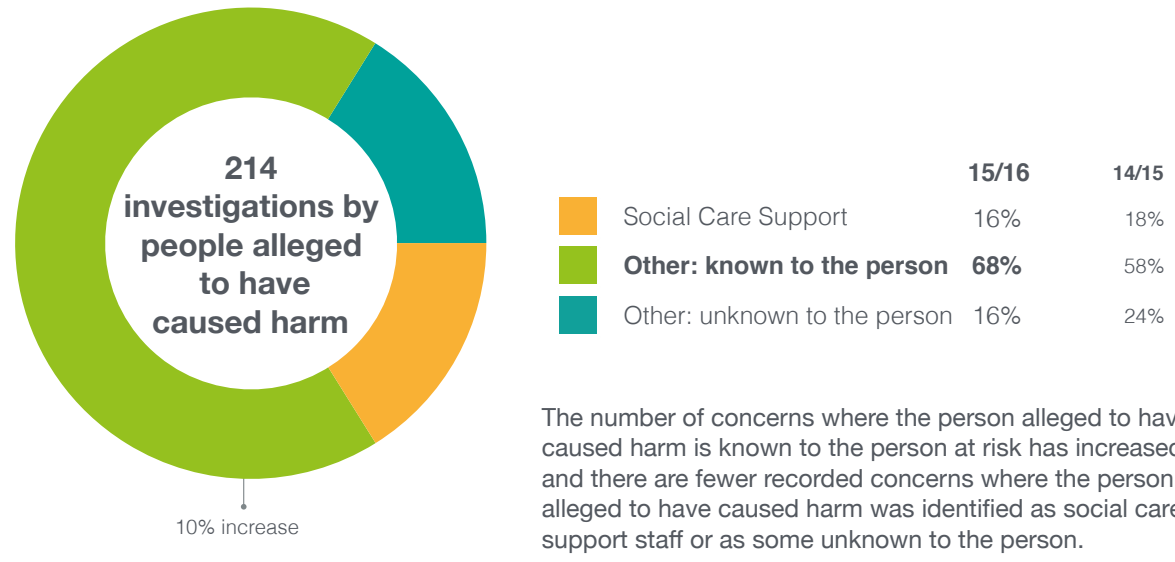


LBH received **661** safeguarding concerns (formerly known as 'alerts'), slightly fewer than in 14/15. Concerns remain at a high level compared to five years ago, although the trend of increasing in number year-on-year has stabilised.

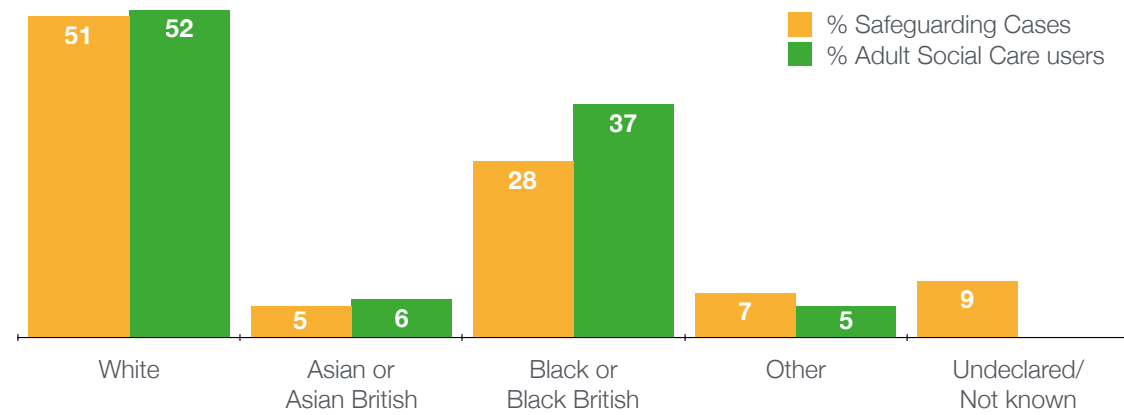
Overall, there is a broad consistency in the number safeguarding concerns over the last 4 years. The implementation of the Care Act and the safeguarding publicity campaign held in 2015 have not resulted in an increase in safeguarding referrals across Hackney.



There has been an increase in the number of concerns that occurred in peoples' homes and in hospital. There has been a decrease in the number of concerns reported to have occurred in care homes and in the "other" locations.

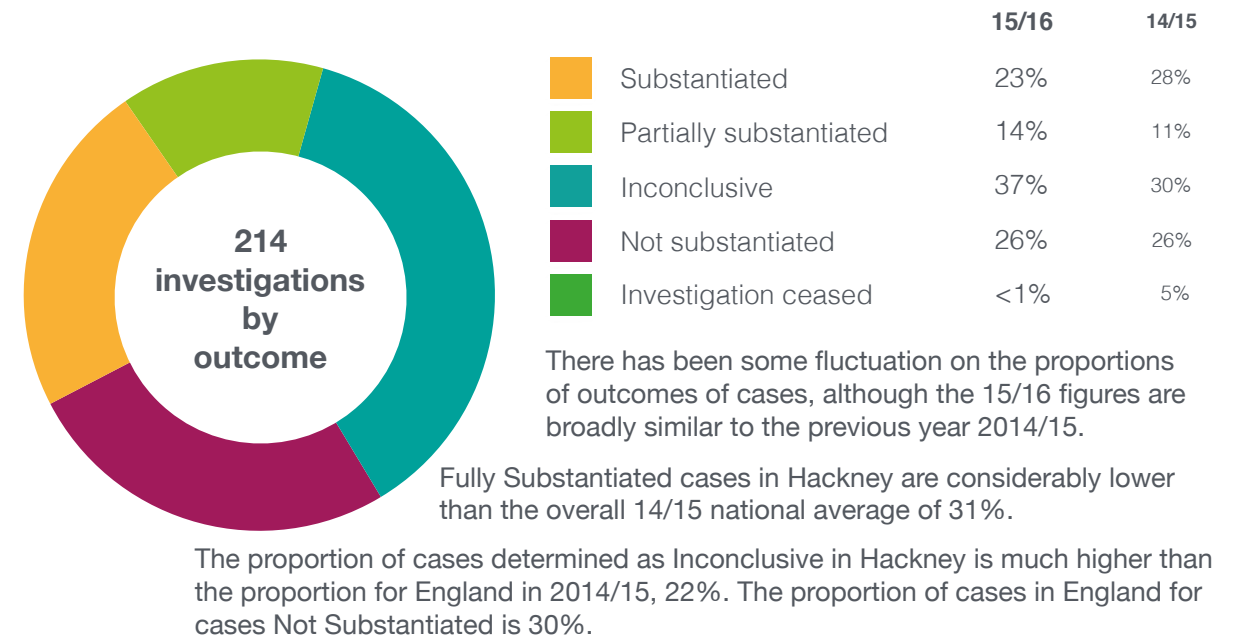


Percentage of ethnic profiles of accepted Safeguarding Cases compared with ethnic profile of people using Adult Social Care service in 15/16



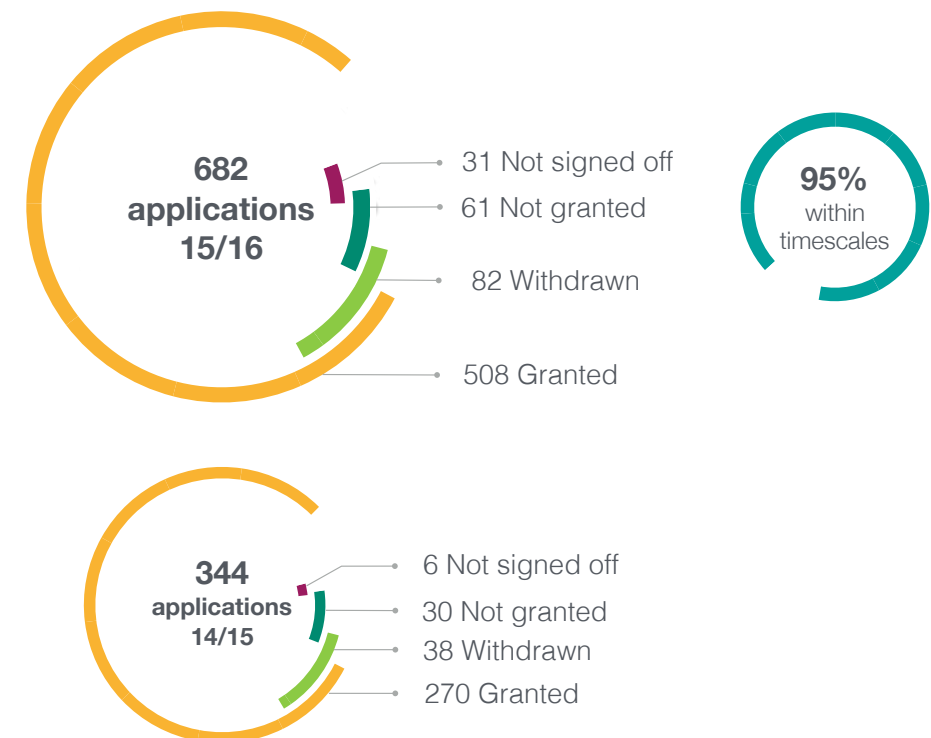
As with last year, there is a notably greater proportion of members of the black community who are using social care services compared to the proportion of the same community who are the subject of safeguarding investigations.

Adult Social Care Services now work with a higher proportion of White clients compared to last year, meaning that the proportion of people in White group who are the subject of safeguarding investigation is more in line with the proportion of people using social care services.



London Borough of Hackney Deprivations of Liberty applications data

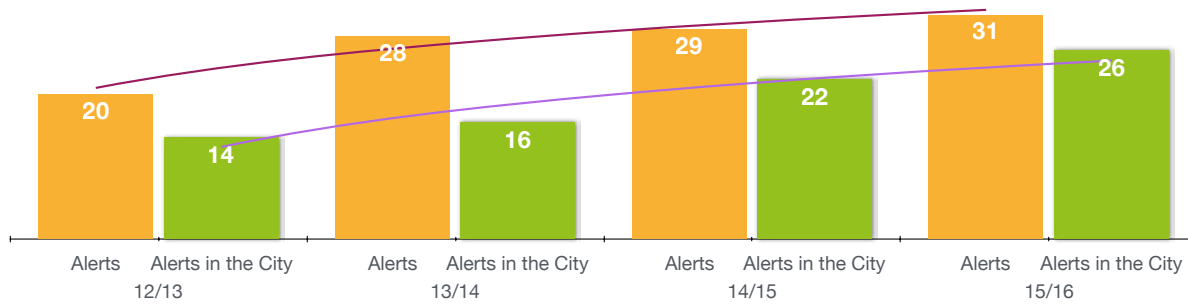
In 2015/16 there were 682 applications for deprivations of liberty, up from 344 applications in 2014/15. This continues the pattern of a radically increased DoLS workload each year since the Supreme Court's judgment in the "Cheshire West" case in March 2014. By comparison, there were only 23 applications for deprivations of liberty 2013/14, of which 13 were approved.



Adult Safeguarding Activity 2015/16

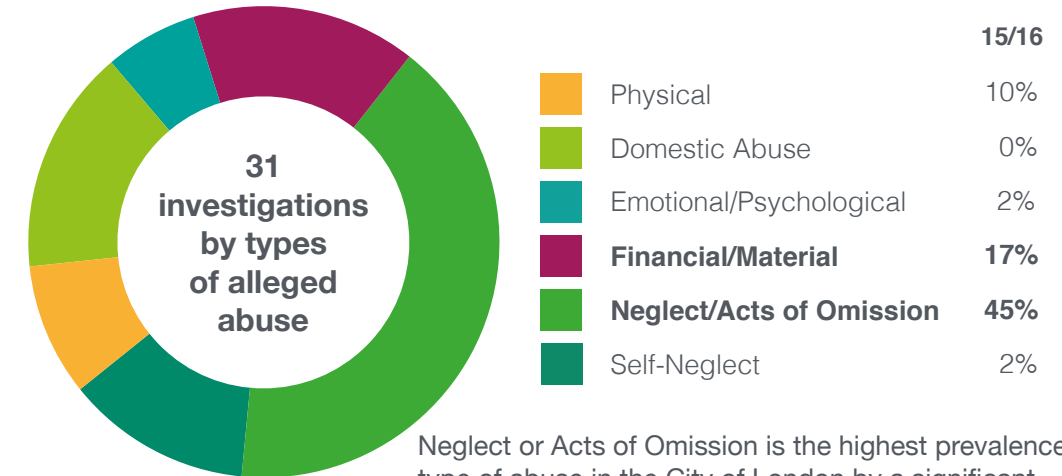
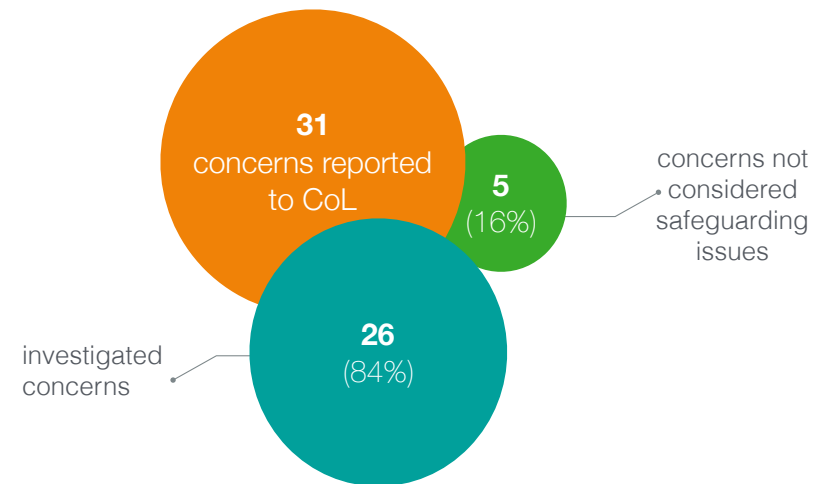
City of London safeguarding data

Alerts/Concerns reported to CoL, from within and beyond the City (2012/13 to 2015/16)

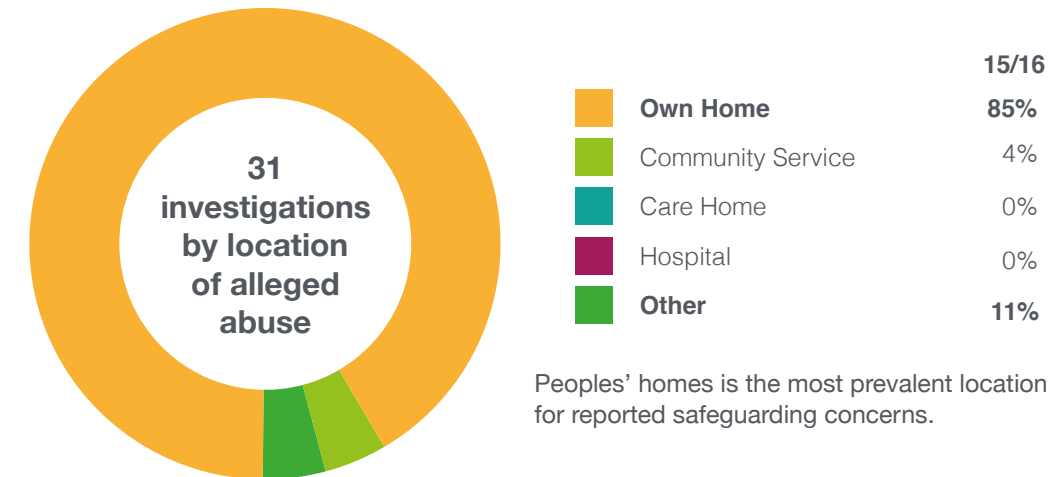


The City of London received 31 safeguarding concerns (formerly known as 'alerts') in 15/16, 26 of these within the City. A gradual increase in concerns has continued since 12/13. This is a positive outcome of professionals' and residents' increased awareness and understanding of adults at risk.

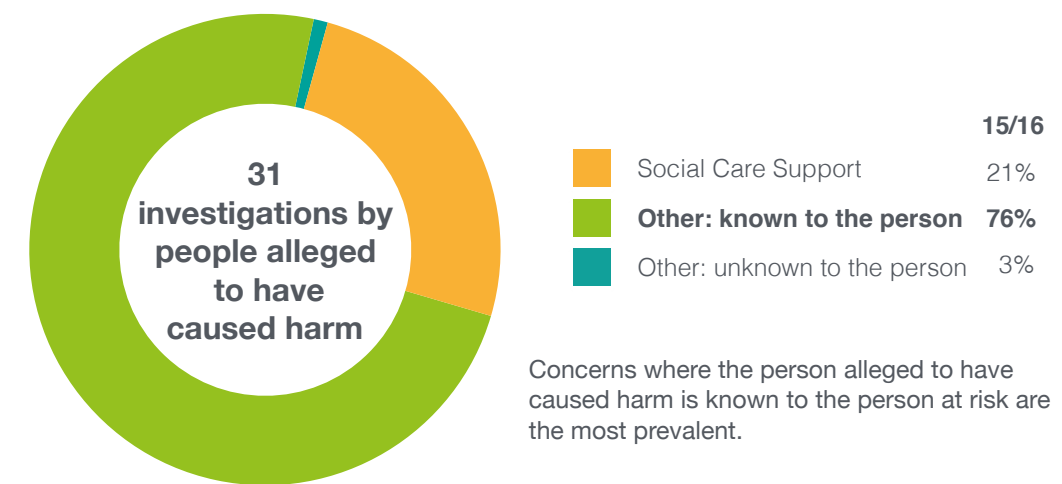
LBH received 661 safeguarding concerns, slightly fewer than in 14/15 (672). Just over a third, 257, were progressed as a safeguarding matter, again slightly fewer than in 14/15 (270).



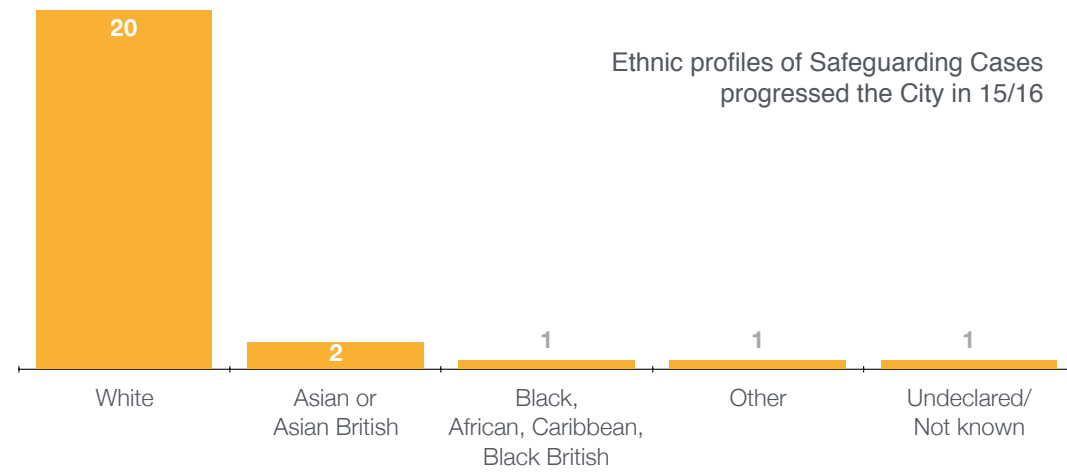
Neglect or Acts of Omission is the highest prevalence type of abuse in the City of London by a significant margin. Financial or Material cases are the second most reported type of abuse concern.



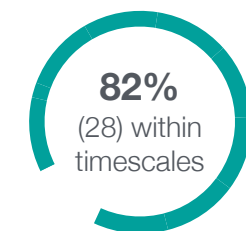
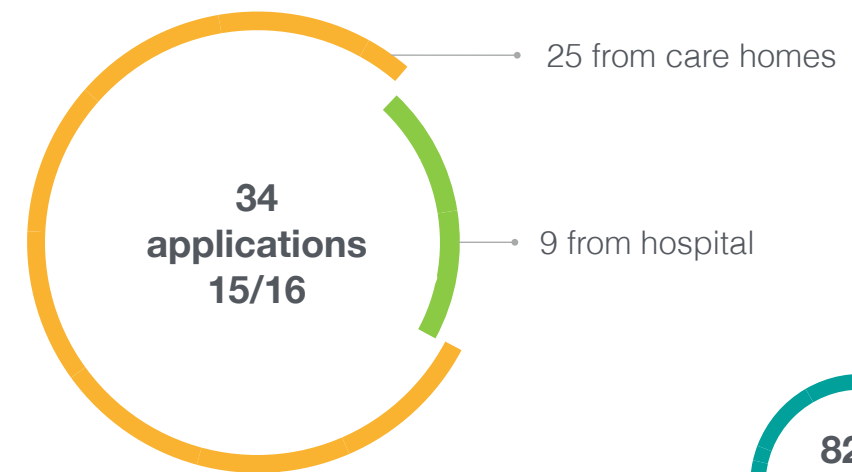
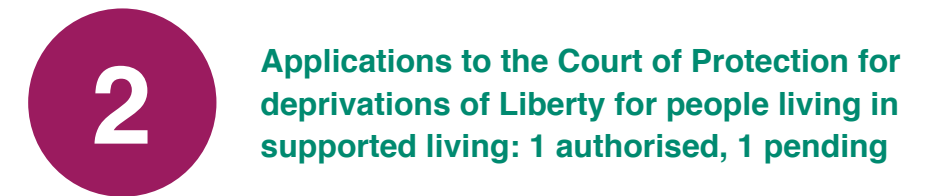
Peoples' homes is the most prevalent location for reported safeguarding concerns.



Concerns where the person alleged to have caused harm is known to the person at risk are the most prevalent.



City of London Deprivations of Liberty applications data



Partner Contributions

In the next section CHSAB partners set out how they have contributed to the work of the CHSAB and to the ongoing improvement of local safeguarding adults arrangements. Each key partner was asked to frame their contribution in response to the following key questions:

What has your agency undertaken to meet the CHSAB principles?

What difference has your agency made to improve the safeguarding of adults and in promoting their welfare?

How does your agency evaluate its effectiveness and what evidence do you have?

How has your agency challenged itself and others to improve safeguarding arrangements? What were the risks and impact of your challenge?

City of London Corporation and partners

Marion Willicome Lang

Adult Social Care Service Manager



1. What has your agency undertaken to meet the CHSAB Principles?

All our learning will be shared learning

The Department of Community and Children's Services (DCCS) Business Plan 2015-17 has as its first strategic priority, 'Safeguarding: Ensuring effective arrangements are in place for responding to safeguarding risks, promoting early identification and support to prevent escalation of issues and keeping children and adults at risk safe.'

The City of London Adult Social Care (CoLASC) team has primary safeguarding responsibility for adult residents of the Square Mile. As a generic adult social care service, safeguarding responsibilities apply to anyone over 18 who has an additional need, including the needs of their carers.

The CoLASC service is accountable to the Community and Children's Services Grand Committee and reports directly on adult safeguarding matters to the member-led Safeguarding Sub-Committee. This fulfils the type of scrutiny function associated with other local authority scrutiny governance structures. A member of the Safeguarding Sub-Committee is also a member of the CHSAB. Another member is the Rough Sleeper Champion and chairs the Adult Advisory Group.

The City of London Adult Safeguarding Sub-Committee, now chaired by Dr Adi Cooper, provides greater understanding and accountability on the part of officers and partners as to their responsibility to safeguard adults in the City of London (CoL). This is an important conduit for cascading messages from the CHSAB and a means of developing a City-specific work plan in line with the Board's priorities. CoLASC representatives sit on this Sub-Committee and provide regular practice updates and performance data which are open to challenge, scrutiny and learning. The Director of DCCS and Assistant Director for People sit on the CHSAB. The AD sits on the CHSAB Executive Board and chairs the SAR sub-group. The CoLASC Service Manager and Team Manager sits on the SAR and Training & Development sub-groups.

The City of London held training sessions and briefings regarding adult safeguarding for members sitting on the Safeguarding Sub-Committee. These aimed to provide greater clarity on adult safeguarding to members who in turn can provide challenge and scrutiny on the performance and practice of the CoLASC team.

Following from an independent audit of the CoLASC service in 2014/15, an Improvement Plan was developed and implemented over 2015/16. The plan was RAG-rated and reported on at Safeguarding Sub-Committee and through the Adults Senior Management Team meeting forum.

Through case supervision the CoLASC team has worked on learning alongside individual case audit templates. Learning from the Improvement Plan has also been shared with practitioners at service team meetings.

The draft recommendations of Mrs A & Mr B SAR have been presented to the CoLASC team in an extended team development session with the compilation of a localised Improvement Plan. Five key learning points from the SAR were developed by and for the CoLASC service:

1. Reviewing CoL supported living contracts with Commissioning colleagues
2. Reviewing CoLASC risk assessment processes
3. Reviewing CoLASC working practices with clients out of borough on the Care Programme Approach
4. Training standards of staff in contracted supported living service in the CoL
5. Fire risk training standards across CoLASC and LFB jointly - to be raised at Safeguarding Adults Sub-Committee

The CoL has adopted the revised London Multi-Agency Adult Safeguarding Policy & Procedures, which have been fully disseminated in CoLASC the team in electronic and individual hard copy pack formats. Development sessions held at each fortnightly team meeting since January 2016 embed safeguarding awareness and understanding.

Each CoLASC team member's individual learning objectives will highlight safeguarding practice and include specific mandatory safeguarding learning and development goals. These are tailored to the person's post.

CoLASC attended the following training rolled out to partners of the CHSAB following the publishing of the new Multi-Agency procedures:

- Safeguarding Awareness (Alerter) ½-day session (3 members of CoLASC)
- Coercion & Emotional Abuse ½-day session (5 members of CoLASC)
- Domestic Violence ½-day session (4 members of CoLASC)
- Domestic Violence 1-day session (5 members of CoLASC)
- Modern Slavery ½-day session (5 members of CoLASC)
- Self-Neglect & Hoarding ½-day session (6 members of CoLASC)
- Autism Awareness ½-day sessions (2 members of CoLASC)

The current provider of the CoLASC's community provision, Toynbee Hall, delivered workshops with City residents to raise awareness of adult safeguarding. The workshops allow discussions and learning so that participants become empowered to make decisions, and seek support where necessary. This has been especially effective with participants with learning disabilities as a number did not realise financial abuse was a type of abuse and does not need to be tolerated. The workshops have also enabled Toynbee Hall to be made aware of participants' concerns and raise cases with CoLASC.

We will promote a fair and open culture

The CoLASC team has continued to work with commissioning colleagues to ensure that safeguarding is embedded within the contracting and commissioning process. A current recommissioning process of all CoLASC community provision has seen safeguarding as a key priority in the tendering process, which includes a case study and an explicit safeguarding training & development question. There is currently a Domiciliary Care service specification being devised and CoLASC are working closely with commissioning colleagues to ensure that safeguarding is embedded fully within the tendering and contract process.

The CoLASC service, along with all partners of the CHSAB, completed the London Chairs of Safeguarding Adults Boards and NHS England's Safeguarding Adults at Risk Self-Audit Tool 2015-16. This identified that CoLASC was meeting 22 of the 29 requirements, with six relevant requirements noted as requiring additional action. This assessment provided strong evidence of the priority and commitment shown towards safeguarding adults at risk, from the golden thread of the Corporate Safeguarding Strategy, highlighted within the DCCS Business Plan, through to the core business and professional practice of the Adult Social Care Service. The assessment and CoLASC representatives then contributed to the support & challenge sessions at the SAB Development ½ Day in February 2016.

As a service within the Department for Community and Children's Services, CoLASC has full access to an escalation policy, as well as access to the AD and Director if issues remain unresolved at an operational level.

We will understand the complexity of local safeguarding needs

With the inclusion of Self-Neglect and Hoarding into the London Multi Agency Adult Safeguarding Policy and Procedures, the City of London has adopted the City & Hackney Self Neglect and Hoarding Protocol, and has set up a Self-Neglect and Hoarding Panel, chaired by the Adult Social Care Service Manager. The panel commenced in January 2016 and has partner involvement from London Fire Brigade, City of London Police, Environmental Health, Public Health, a City of London legal advisor, City of London Housing, primary care GP representation on a case by case basis and an independent hoarding specialist organisation MRS (Making Room Service, who are a commissioned member of the One Hackney and City Voluntary Sector Framework).

This panel has been working very effectively with five cases discussed to date, and multi-agency pathway plans developed on each case.

Ongoing work has taken place this year with commissioning colleagues to ensure any safeguarding work that includes our commissioned domiciliary care agencies or residential or supported living placements are followed up contractually and through CQC. CoLASC has also worked with commissioning colleagues to draw up a new specification the retender of Adult Social Care's community provision - the Reach Out Network; a memory group, a carers support group and an adult support group (The Wellbeing and Independence Service (WISE)). This has placed safeguarding practice at the heart of the new contract. We have sought to embed the vital importance of early intervention and prevention within commissioned community provision, as the eyes and ears of the community. An outcomes-based approach to capturing effectiveness is being developed.

An outcomes-based specification in the retendering of domiciliary care provision within the City that seeks to hold services to account for their direct care provision to our most vulnerable service users in the community will also provide an opportunity to embed adult safeguarding processes.

The skill base of our staff will be continuously improving

A City of London Corporation Safeguarding Policy is now in place, which has raised the profile of Safeguarding Adults and Children across the Corporation. Safeguarding is now on the Corporation Risk Register. These high level elements coupled with the *Notice the Signs* safeguarding Campaign conducted throughout 2014/15 has assisted in greater understanding and awareness of Adult Safeguarding for both city staff and residents.

A Corporation Safeguarding Champions meeting takes place quarterly, chaired jointly by the Service Manager for Adult Social Care and Safeguarding and the Quality Assurance Service Manager, which aims to improve knowledge and understanding of safeguarding for non-social care staff.

The CoLASC Service Manager holds the role of Adult Principal Social Worker, is a member of the London Safeguarding Adults Network and is the ASC lead on Modern Slavery. These roles and duties enhance the social work development brief around competent safeguarding practice, alongside the current scrutiny provided by the case audit work of the CoLASC Senior Management Team. The developing peer support between the CoLASC Service Manager and the Hackney Head of Adult Safeguarding has been very constructive in focusing a generic role to consider safeguarding solely from a specialist post's perspective.

Positive results from pooling good practice in safeguarding has meant the sharing of the Hackney Adult Social Care Safeguarding Policy, alongside new safeguarding workflow templates between the two different electronic social care record systems used by Hackney and the City of London (Mosaic

and Framework-I, respectively). A City of London Case Audit template will be trialled in 2016, and will include a key performance indicator focused on capturing the requirement to keep the person who raised the safeguarding concerns updated as to the outcome. This has been worked on collaboratively across the two authorities. There is also a plan to work jointly on a public awareness raising campaign around Making Safeguarding Personal (MSP) in the autumn of 2016. The CoLASC Service Manager is also the named lead to complete the MSP 'Temperature Check' exercise for the Association of Directors of Adult Social Services in the summer 2016.

CoLASC has worked hard this year to embed the principles of Making Safeguarding Personal. Workflows have yet to be built to make it possible to fully report on this qualitative measure, but evidence of MSP safeguarding adults casework was reported on as part of the independent audit conducted in 2015 and this sound social work practice has continued to be evidenced through case audits and supervision notes.

There is clear evidence of MSP through the increased presence of the adults at risk of or experiencing abuse and neglect and their family members being involved and attending meetings throughout the safeguarding process. There is also an increase in the use of safeguarding-specific advocacy.

New safeguarding templates prompt social workers to consider the person's desired outcomes at the beginning of the safeguarding process and again at the end. The social workers have spent time at a recent team away day looking at this and how to be more MSP outcomes-focused in their adult safeguarding work.

The Knowledge Transfer Partnership with City of London and Goldsmiths University has developed a safeguarding agenda around social isolation and loneliness. A learning and development day which was attended by Dr Adi Cooper and the Chief Social Worker for Adults Lynn Romeo was highly effective in raising awareness of the risks of safeguarding in conjunction with the loneliness and isolation of many older people.

The CoL Workforce Development group is about to be developed through the Senior Management Team, and a training matrix around safeguarding will reflect these developments in coming months. It is hoped that level 1 Safeguarding Awareness training will become a mandatory training course across DCCS, departmental Corporate Safeguarding Champions and nominated departmental representatives.

Victim Support safeguards adults by raising awareness about safeguarding and rights with victims and witnesses who use our services. Staff regularly read up on safeguarding policy from both internal as well as external resources. This can be evidenced through quarterly meetings with staff and senior management. This has helped staff in their performance and quality of work as they have a sound knowledge and understanding of the safeguarding policy and procedures.

Victim Support staff also attended external training around safeguarding such as the Multi-Agency Safeguarding Team training. This looked at how partners could identify and appropriately refer safeguarding concerns to the relevant service. Staff were also encouraged to attend the Pan-London conference which enables them to network with other professionals but crucially learn more around appropriate ways to identify and adequately support safeguarding concerns.

2. What difference has your agency made to improve the safeguarding of adults and in promoting their welfare?

Please refer to the earlier section for City of London data adult safeguarding and Deprivations of Liberty. The CoLASC team completed 54 carer's assessments in 2015/16. Safeguarding Carers was focused upon during a London ADASS peer review of our compliance with the Care Act regarding working with carers, and CoLASC's approach was commended by the Peer Review Team in 2015.

CoLASC have worked very successfully in parallel with Multi-Agency Risk Assessment Conferences (MARACs) on four cases of domestic abuse that involved one or more people who have an additional need. Collaborative work has been especially effective alongside housing partners and the City of London Polices Public Protection Unit colleagues and Vulnerable Victims and Domestic Abuse Coordinator.

CoLASC have seen an increase in the number of safeguarding cases where mental capacity is an issue. There has been an increased use of and subsequent pressure to obtain Advocates and Relevant Persons Representatives in line with both the Care Act and The Mental Capacity Act. CoLASC is working with commissioning to remedy this issue.

Toynbee Hall's Dignify awareness raising project aims to reach older people and those with mental health issues. Workshops have been delivered at a variety of settings which include City residents attending Toynbee Hall sessions as well as sessions based through City 50+ coffee mornings.

3. How does your agency evaluate its effectiveness and what evidence do you have?

CoLASC along with all partners of the CHSAB has completed the NHS England Safeguarding Adults at Risk Audit Tool 2015/16, and highlighted areas for improvement.

CoLASC seeks to be open to the scrutiny and challenge of officer and member led safeguarding committees, as well as taking on board the challenges of the CHSAB Quality Assurance sub-group and continuing to develop through peer support and challenge with Hackney. Going forward we will adopt the Hackney case audit tool and continue to utilize the safeguarding tool kit devised for practitioners following the last Safeguarding Adults Review in 2014/15

The resident workshops led by Toynbee Hall evaluated their effectiveness by asking participants to identify types of abuse, symptoms of abuse and also where to go if you are concerned about abuse. After participation in the sessions, generally 80% of participants are able to report this.

At Victim Support the National Safeguarding Lead Officer completes an annual audit of safeguarding referrals, organisational responses, trends and impact across the organisation for the Board of Trustees. Project staff are able to evaluate safeguarding every week as part of their case review meetings. Additional to this staff have monthly team meetings in which they are able to speak about difficult cases and share good practices. Lastly the designated safeguarding officer always follows up on any referral made and looks to speak with the support worker around the case and where applicable better methods to handle future cases.

4. How has your agency challenged itself and others to improve safeguarding arrangements? What were the risks and impact of your challenge?

CoLASC has sought to ensure that Intake and Duty are staffed by qualified social workers so that all safeguarding concerns are followed up in a timely manner. A business case was made in relation to the Care Act to employ a senior practitioner to further develop the service and offer duty advice and guidance including Safeguarding Adult Manager (SAM) scrutiny on all incoming work.

CoLASC seeks to use the scrutiny of Members as well as the SAB and SAR sub groups to be open to challenge.

CoLASC seeks to analyse specific case work where better outcomes were felt to be achievable for service users and use team meetings and developmental sessions to analyse these findings as lessons learnt for improved practice.

Safeguarding quarterly data reports are published for senior managers and Members and performance is analysed. This is seen as a challenge exercise to provide narrative and ensure we understand our safeguarding processes and timescales.

Through contract monitoring, CoLASC seeks to have a presence to ensure operational safeguarding practice is fully raised and addressed within our commissioned services.

Toynbee Hall recently took part in a safeguarding Challenge & Support panel session with Tower Hamlets SAB. This work will also benefit Toynbee Hall service provided to City of London residents. As a result of this Toynbee Hall have reviewed their Safeguarding Policy, obtained a peer review of the new policy, organised online training for new starter staff and volunteers, included 'safeguarding' as a prompt for team meetings and one to one supervisions and included a 'safeguarding' prompt for Exit Interviews to see how staff felt the organisation manages any concerns or disclosures.

Victim Support challenges itself through regular reviews of its service. Feedback is sought from clients and partners in order to effectively evaluate the service we provide. Where negative or average responses are found, the service looks to find new and innovative ways to improve delivery of services. Furthermore, the internal training team constantly look to improve both the online as well as practical in office content offered to staff and volunteers.

City of London Priorities for 2016/17

- Organising and securing funding for Mandatory Level 1 Safeguarding Awareness training for staff and providers within CoLASC
- Safeguarding training for CoLASC around new safeguarding adults policy and procedures.
- Working with Hackney on MSP public awareness raising campaign
- Developing an MSP outcomes approach that can be reported upon effectively
- Raising awareness in the City to financial abuse
- Addressing safeguarding linked to social isolation
- Addressing domestic abuse (from a *Think Family* perspective through collaborative work with City Safeguarding Children Executive Board)
- Progressing the Carers Action Plan to ensure positive outcomes are maximised and carers are supported to fulfil their caring roles
- Progressing work to support Self-Neglect and Hoarding issues in the City
- Developing the new five adult safeguarding procedural stages under the London Multi-Agency Procedures over 2016/17, putting in place training and new templates and workflows in Framework-i

City of London Police

Angie Rogers

Detective Chief Inspector,



Priority & Volume Crime

1. What has your agency undertaken to meet the CHSAB Principles?

The City of London Police Force (CoLP) has a Public Protection Unit (PPU) that comprises of one detective inspector, two detective sergeants and eight detective constables. The Unit has a large remit including domestic violence, rape and sexual offences of adult and children, child protection, child deaths and management of sex offenders. They also investigate any safeguarding of adults at risk crimes which come under a professional or care setting. The work of the Unit and CoLP has supported the CHSAB principles variously.

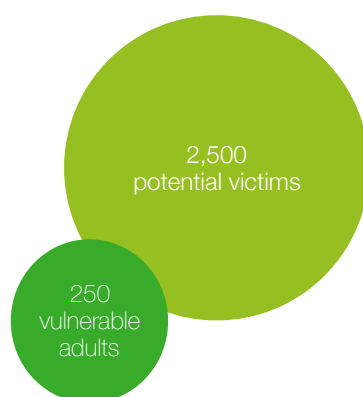
CoLP attended a number of multi-agency meetings that relate to safeguarding adults including the CoL Adult Safeguarding Sub-Committee, MARAC and MAPPA meetings, the CoL domestic abuse forum, the CHSAB Quality Assurance sub-group and other meetings under the Board.

The PPU introduced an internal safeguarding meeting in 2016, merging several existing meetings and taking on additional issues for consideration. This meeting is chaired by DCI Rogers and is represented by the Force as a whole. The meeting covers all areas of public protection work and safeguarding and it examines the way the force responds to safeguarding, any implications these issues may have for the force and continuous improvement. Actions are raised in the meeting and allocated throughout the Force to make sure there is a joined up response to safeguarding and that it is embedded as everyone's responsibility in practice.

The Economic Crime Directorate has created an Economic Crime Victims Care Unit (ECVCU) which comprises six advocates. The advocates contact potential vulnerable victims of fraud based in London, including the City, who have not had their crimes investigated, ascertain their vulnerability and refer them onto the appropriate support services. They also supply advice on crime prevention and how not to become a repeat victim of fraud.

2. What difference has your agency made to improve the safeguarding of adults and in promoting their welfare?

The City of London Police Force's (CoLP) Economic Crime directorate has dealt with over 2,500 potential victims London wide and has identified approximately 250 of them who were vulnerable. The PPU has also built up good working relationships with partner agencies such as Age UK and VSS raising their understanding and awareness of victims of fraud.



The CoLP has been experiencing a recent, significant increase in members of the public entering the water from City of London's bridges. There have been a number of fatalities. The volume of 'near misses' (where powers under Section 136 of the Mental Health Act 1983 have been exercised) has also increased.

The CoLP took part in a multi-agency campaign was involving the Corporation of London, the London Samaritans and the Metropolitan Police in April and May. This initially involved a leaflet handout on London Bridge. Leaflets were given to members of the public pointing out the issue and giving advice on actions to take if concerned with any individuals seen. Some 2,500 leaflets were distributed. The campaign then delivered letters to businesses in and around the bridges inviting people to attend 'Suicide Prevention' training held in a local venue and given by London Samaritans. 250 letters were given out and a total of 25 people attended the two training sessions. There are plans to conduct a similar campaign in the Tower Bridge area in the near future. Additionally, the CoLP are seeking to establish a 'Bridges Working Group' on an interim basis to address this issue. Listed below are the preliminary principles/steps that the CoLP wish to implement:

1. The principal objective is to assess whether we are taking the necessary steps to safeguard vulnerable members of our communities from harm.
2. As this is an issue that impacts on both the City of London and other London Boroughs, the CoLP will be seeking representation from Lambeth, Southwark and Westminster MPS Boroughs in order to share experience, good practice and working solutions.

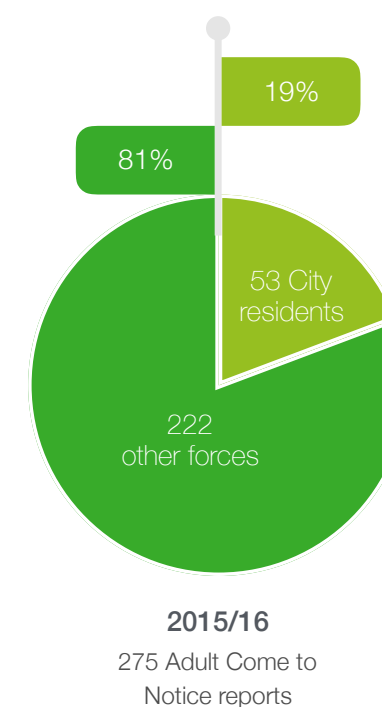
3. How does your agency evaluate its effectiveness and what evidence do you have?

The implications of the Care Act and the Vulnerable Adults Framework were relayed to all the City of London Police Force's uniform response officers last year (see the Metropolitan Police contribution later in this report for more information on the Framework) and there will be refresher training this year provided by the PPU and the Crime Policy Team.

A new process was also added to Police systems to log adults at risk who come to Police attention ('Adult Come to Notices'), which has been hugely successful. In the period 2015-16 we have received 275 ACN's 53 of which are City residents and 222 which were from other force areas.

CoLP also give an extremely quick response to any contact from Adult Social Care and are on hand to complete checks and give advice as necessary.

The ECVCU unit conducts victim satisfactory surveys, finding that 100% of victims said they were provided with practical help and advice, while 83% of victims said they had taken measures to reduce the risk of them becoming victims of fraud again. We also review victim data to ensure that no repeat victims have been identified.



4. How has your agency challenged itself and others to improve safeguarding arrangements? What were the risks and impact of your challenge?

The Police's ECVCU unit has conducted a review of its operating procedures and improved the referral processes. They have identified a new 3 tiered approach to victim support and the Economic Crime directorate is also scoping new processes that will improve the fraud victims' 'journey' through the criminal justice system, catering for all victims of fraud whether there is an investigation or not.

The CoLP Safeguarding meeting is also used as a forum to share information and constantly review internal and joint agency working and to continue to make improvements across all aspects of safeguarding.

London Borough of Hackney Council



Cath Millen

Head of Adult Safeguarding

1. What has your agency undertaken to meet the CHSAB Principles?

Hackney Adult Social Care (HASC) is a partner member of the CHSAB, the CHSAB Executive Group all of the Board's sub-groups with the exception of the City of London Sub-Committee. HASC is therefore actively involved in the majority of aspects of the strategic development of adult safeguarding in the City and Hackney. Examples of this work are:

- Development of the Safeguarding Adults Review (SAR) protocol by the HASC Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) lead
- Formulation and submission of comments on behalf of the CHSAB to the Law Commission in relation to their proposals to revise the DoLS process by the HASC DoLS and MCA lead
- Development of the CHSAB Self-Neglect (including chronic hoarding) protocol by the Head of Adult Safeguarding, which the CHSAB approved in September 2015 and is currently being trialled. This protocol will be reviewed in June 2016. All agencies represented on the CHSAB had the opportunity to contribute to the draft document and will have the opportunity to be a part of the review.

HASC is an active member of multi-agency forums such as Multi Agency Public Protection Arrangements (MAPPA), Multi Agency Risk Assessment Conferences (MARAC), the Anti-Social Behaviour Panel (ASBAP), Prevent Partnership Meetings (PPG) and the Channel Panel. The multi-agency forums mentioned above provide an excellent opportunity for shared learning and increased understanding of local issues. Both the chair of the MARAC and the Domestic Violence & Abuse Team (DVAT) Transformation Manager have fed back that the input into the MARAC by the HASC community safety lead is extremely useful and informative.

In November 2015, HASC set up the Community MARAC panel, which it chairs and provides administrative support for the panel. The panel hears cases, which have been assessed as very high risk. It has been set up to deal with a range of risk issues including self-neglect, unlike the conventional MARAC, which is solely focused on cases of domestic abuse. The Community MARAC membership includes a range of agencies such as the police, housing with care, London Fire Brigade, etc. Representatives are relatively senior managers in their agency in order that they can provide direction and advice on actions that might be taken by their agency. Although still within its pilot phase, the Community MARAC has already facilitated improved outcomes for the adults

at risk whose cases were presented due to the shared expertise of the professionals from the different agencies make up the panel.

The two senior practitioners in the Safeguarding Adults' Team (SAT) have proactively engaged with partners and contributed to shared learning, for example, they have presented at various forums such as the Association of Palliative Care Social Workers, the trainee Learning Disability Psychiatrists for London, and St Joseph's Hospice. One of the senior practitioners continues to produce a widely popular comprehensive bi-monthly safeguarding newsletter, which also covers mental capacity and deprivation of liberty. This newsletter is posted on the intranet and sent to a range of partner organisations. Feedback on the safeguarding newsletter from HASC staff and partner agencies has been very positive.

HASC has adopted the London Multi-Agency Adult Safeguarding Policy & Procedures and written a short local safeguarding document that sits alongside it. It has shared this document with the City of London.

Over the past few months, HASC has developed a new safeguarding case management workflow and new safeguarding forms and which reflect the revised multi-agency procedures. These have also been shared with colleagues in the City of London. The development of both the workflow and forms was undertaken using a co-production process with front line staff and senior practitioners. Their involvement and feedback was vital to ensure that the process and forms would be clear and effective in practice. In the future, a group of people who use services will be involved in the development process - for example, Hackney's User and Carer Reference Group will be asked for their involvement when the process and forms are reviewed in September 2016.

In terms of improving shared learning, a priority for next year is to ensure that referrers of safeguarding concerns receive feedback on their referrals. This current gap has been identified by various partner agencies such as the London Ambulance Service and the police (in relation to MERLIN reports) as well as by the CHSAB Board Manager and through the CHSAB's public strategic consultation. Social workers have been asked and are expected to feedback to referrers and a mandatory question is now being added to the safeguarding workflow to ensure this takes place.

The Head of Adult Safeguarding and the Transformation Manager for DVAT have worked closely together this year and developed a joint protocol for staff with the aim of increasing awareness of each other's services and increasing the number of referrals from HASC to the DVAT. The DVAT manager has presented to the HASC Service Managers meeting and has presented at the domestic abuse training sessions held in early 2016 to provide local context and information about the DVAT. The SAT community safety lead has produced a document on safeguarding for the DVAT and has spoken at their team meeting. The number of HASC referrals to MARAC has increased from zero in the year 2014/2015 to six in the year 2015/16. The Transformation

Manager has reported that number of referrals to the DVAT from HASC has increased by 50% in the last 6 months.

HASC and London Fire Brigade (LFB) have also worked closely together this year to address the issue of the low level of referrals from HASC to LFB for home fire safety checks. This has included LFB providing training to staff in the social work teams and provided services. The LFB have reported an increase in referrals over the last six months but have said that the level of referrals is still lower than expected, suggesting that further work is needed in this area. Thirty-six referrals were made by HASC in 2015/2016. LFB do not have the data for 2014/2015 but have stated that thirty-six is a significant increase on the previous year.

To further improve joint working between Children's and Adults services, the Head of Adult Safeguarding has set up six weekly meetings with the Head of Children's Safeguarding and one of the Children's Service Managers. This is working well in terms of developing understanding of each other's services and how to improve partnership working.

Monthly SAM meetings have been set up in order to provide more support to the Safeguarding Adults Managers (SAMs), who are the HASC decision-makers in safeguarding cases. This provides an opportunity for relevant speakers, such as the Police and advocacy services, to come and present and for the SAMs to feedback on issues affecting them and to discuss complex cases.

Alternate safeguarding and mental capacity monthly surgeries have been set up for front line staff to discuss complex cases/issues with a member of the safeguarding adults team (SAT).

A Positive Risk-Taking & Risk Management Policy was written, distributed to staff and placed onto the intranet to develop day-to-day social work practice. It has subsequently been expanded based on the draft findings of the Mr BC Safeguarding Adults Review (see above), which the CHSAB will report on in more detail next year.

Furthermore, a HASC escalation policy has also been developed so that staff are aware of the process to follow if they encounter inter- or intra-agency disagreement on practice issues.

Following the implementation of the Care Act 2014, a draft Designated Safeguarding Manager (DASM) Policy and Procedure was developed in 2015. This document has been amended as a result of the revised Care Act guidance, which removes the DASM role. The document now outlines the responsibilities of the Heads of Adult Safeguarding and Human Resources in relation to any adult safeguarding allegations made against an employee of Hackney.

Joint work is being undertaken with Children's Services to develop an operational protocol for dealing with Modern Slavery cases. This protocol

will be presented to both the CHSAB and the CHCSB in 2016-2017 for approval. Training on modern slavery has been jointly commissioned with the CHSAB, which all social workers are expected to undertake. The Head of Adult Safeguarding is the HASC lead on modern slavery.

Safeguarding training for this year focused on the 'new' categories of abuse under the Care Act statutory guidance and a series of half day workshops were offered. One-day training on domestic abuse was offered in addition to the half-day training for those who required more in depth knowledge. This training was joint funded by HASC and the CHSAB, commissioned by HASC and was open to all CHSAB partners. Following staff feedback on SAM training, which indicated that it did not focus sufficiently on complex cases and making difficult decisions, a new provider was commissioned by HASC and the SAM training extended from one to two days.

Prevent is one of the government's four elements of CONTEST, the government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism. The Head of Adult Safeguarding sits on Hackney Council's Prevent Partnership Group and the community safety lead sits on the Channel panel. A HASC Prevent policy has been developed. The workforce development team has developed an action plan to ensure that current HASC staff and new starters in the future access the Prevent WRAP training in 2016/2017 and that the training is geared to adult social care staff. We are in the process of adding information on Prevent to the social work induction pack and the social work handbook. Referral to Prevent is now an option on the new safeguarding forms.

HASC hosted a Making Safeguarding Personal event for social workers in November 2015. Dr Adi Cooper OBE, the CHSAB independent chair, and Lyn Romeo, Chief Adults' Social Worker for England presented at this event. The feedback received via staff questionnaires was very positive with a desire expressed for similar events to be arranged in the future.

The Head of Adult Safeguarding carried out an internal audit of twenty-five safeguarding cases in early 2016, in order to develop a robust understanding of safeguarding practice and to identify areas for improvement. The audit represented approximately 4% of safeguarding cases in the year 2015/2016. The learning and recommendations from this audit will be shared with HASC senior managers and staff. The audit found that whilst most safeguarding practice was reasonably good there are areas for improvement. For example, recording needs to improve, particularly in relation to recording people's desired outcomes, in line with Making Safeguarding Personal guidance. Use of the care management system Mosaic also needs to improve as lack of understanding of how to use the system has skewed performance figures. Another area for improvement is the recording of risk assessments and risk planning. Whilst the actions that took place on cases show that risks had been considered and mitigated there is little recording of risk analysis. There is strong evidence of multiagency working but also signs that sometimes not all of the right professionals have been involved. The safeguarding audit tool

has been added to the generic HASC audit tool and audits will now occur on a quarterly basis.

As part of the practice improvement work, staff and senior manager questionnaires were sent out in early 2016, which focused on social workers support needs around safeguarding. There was an approximate 20% response rate. Whilst staff identified that they are receiving the support that they need, there was also a clear desire for shadowing and mentoring opportunities, more training and simpler safeguarding forms (this questionnaire sent out prior to the introduction of the new safeguarding adults workflow and forms mentioned earlier).

A benchmarking exercise with several other London boroughs was carried out by the Head of Adult Safeguarding to look at how they manage their safeguarding work and to consider the effectiveness of the current remit of the SAT in HASC. The report (including recommendations) is currently being drafted.

Deprivation of Liberty Safeguards applications increased from 344 in 2014/2015 to 682 in 2015/2016. This is due to the impact of the 'Cheshire West' ruling, which effectively lowered the threshold of what constitutes a deprivation of liberty. (Please also see the Hackney adult safeguarding data and DoLS diagrams and commentary in the previous section of this report.)

HASC has met statutory timescales for 95% of DOLs applications in the year 2015/2016. The projected cost of managing the DOLs process in 2016/2017 is approximately £400,000.

This additional pressure has been included in the Council's medium term financial planning forecast and will be addressed as part of its budget setting process.

The HASC MCA lead has been part of a Task & Finish group at the Homerton hospital, which aims to improve doctors' understanding of the DOLS process. The lead was also involved in the East London foundation Trust's (ELFT) DoLS Task & Finish group.

Finally, the Council's new senior management structure has seen the creation of the Children, Adults and Community Health Directorate, which will bring together children's social care, education, adult social care and public health. This will bring even greater opportunities for joint working, information sharing and economies of scale.

2. What difference has your agency made to improve the safeguarding of adults and promote their welfare?

In order to answer this question both quantitative and qualitative information is required. Please see the Hackney adult safeguarding data diagrams for quantitative data and commentary in the previous section of this report.

The new safeguarding workflow will be able to produce better quantitative data for next year's Annual Report as it asks mandatory questions about the adult at risk's desired outcomes and whether these have been 'fully met, partially met, not met'. However,

for the first time this year HASC has some Making Safeguarding Personal data. While Making Safeguarding Personal questions were not mandatory in the previous case workflow, in 20% of safeguarding cases social workers recorded the adult at risk as having been asked what their desired outcome(s) from a safeguarding intervention or involvement would be. This outcome has then been matched against a dropdown list of options, although no data is available on whether these outcomes were fully met, partially met or not met. The recent safeguarding audit mentioned above showed that in some cases desired outcomes were recorded as free text in the case management system rather than in a reportable format. There should be a far higher level of Making Safeguarding Personal data in 2016/2017 when reporting from the new safeguarding workflow and forms will be available.

Please also see the Hackney adult safeguarding data diagrams and commentary in the previous section of this report.

3. How does your agency evaluate its effectiveness and what evidence do you have?

HASC has evaluated its effectiveness via various mechanisms:

- The complaints and compliments process highlights areas of good practice and areas for improvement.
- HASC has started to measure outcomes of the safeguarding process, including the desired outcomes of the adult at risk.
- HASC uses a safeguarding audit tool. Audits will be carried out on a quarterly basis in 2016/2017.
- HASC completed the NHS England Safeguarding Adults at Risk Audit Tool 2015/16.
- HASC is part of the Safeguarding Adults Review (SAR) process, it is represented in the SAR sub-group and responds to the issues raised within the SARs by action planning to address highlighted issues for the service. For example, the findings of SARs inform training and development of services.

- HASC also seeks feedback from staff via questionnaires, supervision, the safeguarding surgery and safeguarding adults' managers (SAM) meetings and appraisal. For example, the supervision template has a section on safeguarding. As noted earlier, staff feedback has shown that they feel supported in their safeguarding work but would also like access to support such as shadowing and mentoring opportunities.
- HASC receives and welcomes informal feedback from partner agencies. For example, requests for more information for referrers shows a weakness in the current system, whilst the feedback from partner agencies regarding the advice given by the SAT is very positive.
- The Quality Assurance Safeguarding Board, chaired by the Assistant Director for Commissioning, monitors safeguarding concerns raised in relation to commissioned agencies.
- The Head of Adult Safeguarding monitors the number of safeguarding concerns that HASC receives and the time taken to respond to these. The performance team issues weekly reports of outstanding safeguarding episodes and the Head of Adult Safeguarding follows these up with the service.
- HASC also uses its adult safeguarding data to evaluate its effectiveness. Again, please see the diagrams and commentary in the previous section of this report.

4. How has your agency challenged itself and others to improve safeguarding arrangements? What were the risks and impact of your challenge?

HASC has revised its safeguarding processes in line with the London Adult Safeguarding Multi-Agency Policy and Procedures. As noted above, this included developing safeguarding forms that met all reporting requirements (national and local), are streamlined and are practice-focused. From meeting with safeguarding leads from various other local authorities it appears that not all local authorities are making wholesale changes based on the revised Policy and Procedures. For example, unlike Hackney, some local authorities are retaining the investigation and case conference episodes. One of the main risks of making these changes is that staff do not fully understand or make use of the flexibility/proportionality of the new safeguarding process and the quality of practice dips instead of improves. It is too early to assess the impact of the changes as the new system was only implemented in March 2016. It is clear, though, that the new process will challenge social workers to consider the most appropriate, proportionate and least intrusive approaches to individual safeguarding concerns.

The other main risk of using the new approach is that social workers do not fully understand that adhering to Making Safeguarding Personal principles has to be balanced against the level of assessed risk to the person and to others.

HASC has also challenged itself to provide more safeguarding support to staff although resources are limited. For example, the SAT is a very small team, which also manages the DoLS process. As mentioned under question 1, this support has included SAM meetings, safeguarding surgeries, establishing the Community MARAC, and increased access to national and local guidance. This has put increased pressure on the SAT and the social work teams, but the support offered is that which has been requested in staff questionnaires and the feedback has been positive so far.

By working with the CHSAB Board Manager to access CHSAB funding, HASC has managed to put on more safeguarding training at a time when there is a very limited training budget. This has now identified risks attached to it, other than increased pressure on staff time. Feedback on the training has generally been positive. This training should result in increased social work knowledge of the additional categories of abuse under the Care Act and improved safeguarding practice.

The Head of Adult Safeguarding and the lead for mental capacity provided a briefing session on safeguarding for a range of Orthodox Jewish care providers (arranged by Interlink). As a result of this session, the Head of Safeguarding was asked to review the Misgav (service provider) safeguarding policy, which was completed. The aim of the session was to start to build up better links with the Orthodox Jewish community. The risk of holding this type of sessions was of alienating the community, which was minimised by the Head of Safeguarding passing all the information which was to be presented via the Interlink Coordinator prior to the meeting and discussing any culturally sensitive issues with her. A positive discussion was held about safeguarding and mental capacity. However, a lot more work is required in relation to accessing and working with the more 'hard to reach' communities in Hackney and this is a priority for 2016/2017.

Key priorities for 2016/2017

- Ensure that learning from SARS and safeguarding audits is embedded into practice
- Work with the City of London on a Making Safeguarding Personal public awareness campaign
- Work with hard to reach communities to build up understanding of safeguarding adults
- Ensure that referrers of safeguarding concerns receive feedback on their referrals
- Work with staff on developing their understanding and recording of positive risk taking and risk management
- Develop the safeguarding information available on the internet and intranet

London Fire Brigade

Central Operations Directorate



LONDON FIRE BRIGADE

The London Fire Brigade (LFB) services are here to make London a safer place to live, work and visit. We believe that working with our partner organisations to share knowledge and expertise is integral to enabling us to deliver and improve our services. The LFB is therefore committed to adult safeguarding and contributing to Safeguarding Adults Boards (SABs) so that we can support effective partnership working and local arrangements that can protect local residents most at risk of abuse and neglect.

A key aspect of focusing our resources on preventative community interventions that matter the most is by working with others to help protect those residents in the capital who are most vulnerable to the risks of fire. The LFB cannot identify the more vulnerable members of our society on our own so we need our partners to be a gateway to those we wish to target with our fire safety work. We have worked with statutory agencies to develop this aspect of our partnership work. In this way, the LFB will be able to proactively support more residents in our communities to manage fire risks in their own homes.

This year the LFB has continued to support robust adult safeguarding arrangements under the Care Act by:

- Continuing to work with the London Safeguarding Adults Network and a wide range of other organisations that work with vulnerable or disadvantaged groups to let health and social care professionals know about the advice and guidance we can give to minimise the risk of death or injury from fire
- Demonstrating our commitment to safeguarding by making a voluntary contribution of £1,000 to each London SAB to support Boards with achieving their local strategic objectives
- Through this funding contribution required our local authority partners to enter into a Memorandum of Understanding with the LFB, agreeing to improve the lives of vulnerable persons within their boroughs by:
 - making appropriate safeguarding referrals when a concern is raised by the Brigade in carrying out its fire safety function
 - agreeing to consider arranging and holding case conferences on particular cases when a Brigade representative requests following a fatal fire
 - agreeing to make referrals of vulnerable persons to the Brigade to carry out Home Fire Safety Visits

- Instigating a review of our Safeguarding Adults policy & procedures in line with London ones and the Care Act
- Commissioning a new adult safeguarding training package for all staff – elements such as the Mental Capacity Act and the principles of *Making Safeguarding Personal* will form core parts of this package.
- Ensuring LFB representation and contribution to the SABs meetings
- Conducting thousands of Home Fire Safety Visits throughout the year
- Delivering free Fire Safety Awareness training local services where possible
- Working with statutory services to improve the number of referrals for Home Fire Safety visits to the LFB
- Referring Serious Outstanding Risk or Welfare Concerns to the local authorities
- Contributed significantly to Prevent and other anti-terrorist initiatives

The LFB will continue to support the local adult safeguarding arrangements over the next year. We will do this through:

- Continuing to contribute to SAB meetings
- Carrying out Home Fire Safety Visits, particularly targeting those residents known to be at a greater risk of fire
- Continuing to raise awareness of the availability and provision of domestic fire suppression systems for people at significant risk of fire
- Continue to raise awareness of fire risks, especially in relation to people or household more statistically at risk of fire (such as through hoarding)
- When possible, providing Fire Safety Awareness training to local services
- Supporting applications from local housing providers, the local authorities, charitable organisations, care providers and other relevant stakeholders to the LFB Community Safety Investment Fund to receive funding for fire safety systems or equipment.

Hackney CVS

Kristine Wellington

Head of Safeguarding, Children & Families



Our Top 10 Safeguarding Achievements in 2015 – 2016 were:

1. Represented unheard community voices in CHSAB meetings
2. Facilitated the CHSAB public consultation and enabled the VCS to directly contribute to the CHSAB's 5 year strategic plan
3. Development of the Community Safeguarding Engagement Forum
4. Participation in a range of CHSAB sub-groups
5. Increased access to safeguarding training
6. Supported grassroots organisations to navigate the safeguarding landscape
7. Encouraged organisations to include safeguarding on the management committee agenda
8. Connected key VCS-led networks so that they collectively understand adult safeguarding
9. Enabled Third sector to assess how protocols work on the ground
10. Assisted the sector to meet their DBS requirements and funders compliance requirements

Hackney CVS provides both City & Hackney's Safeguarding Adults and Safeguarding Children Boards with the pathways to communicate their key messages to and hear from the diverse voluntary and community sector (VCS). We recognise that the Boards place high value on such multi-agency work.

Over this year Hackney CVS has been active in supporting the work of the CHSAB in its first year of operation under the Care Act. Hackney CVS representatives contributed both to the CHSAB and Executive Group meetings throughout the year and the Safeguarding Adults Review & Case Review sub-group. We also supported the development of and contributed to both the Training & Development and the Communication & Engagement sub-group. The Hackney CVS Head of Safeguarding, Children & Families is the chair of the Communication & Engagement sub-group.

We engaged the VCS significantly to promote the CHSAB's strategic consultation between October 2015 and January 2016, directly supporting the partnership with its statutory duties.

We worked closely with the CHSAB to support the VCS to help to ensure that the sector has a working knowledge of the Care Act 2014, understands and meet its safeguarding compliance requirements, and continues to develop its competence in adult safeguarding. This has encompassed the VCS adult workforce comprised of grant-funded and commissioned organisations that provide a range of services to people aged 18 years and over in Hackney. This has been particularly relevant to frontline organisations working with refugee and migrant communities, faith, tenants' groups, and family support organisations. Overall, Hackney CVS engaged 276 organisations in the adult safeguarding agenda.

VCS Workforce Development

Hackney CVS has continued to work with the London Borough of Hackney's Workforce Development Team to deliver the Safeguarding Adult Awareness courses. The courses were funded by Hackney Council and Hackney CVS hosted the training at our offices in Dalston. Using our offices meant that there was more community-based capacity for people and overall 99 members of the adult workforce benefited from the training.

In January 2016 Hackney's VCS hosted and took part in two specialist courses to advance the sector's knowledge and competency to safeguard adults in Hackney and the City.

1. *Adult Safeguarding - Train the Trainer*

This was a popular two-day event which aimed to create a pool of trainers for VCS organisations so that they can deliver basic and bite-sized Safeguarding Adults awareness training to their frontline staff, volunteers or people using their services – especially at times of the day or week that best enable such people to attend.

2. *City & Hackney Safeguarding Adult Leads (VCS)*

This course helped to equip a service or organisation's named person for adult safeguarding to develop their knowledge and understanding of their role and responsibility.

The CHSAB commissioned the Social Care Institute of Excellence to deliver both these courses.

Additionally, Hackney CVS led a number of funding partnerships and supports partner agencies to understand how to meet their safeguarding and Disclosure & Barring Service requirements, in support of safe recruitment practices.

Grant-funded organisations

Hackney is one of the few boroughs with a community grants programme and over the past few years we have promoted the safeguarding agenda to grant-funded organisations. During this year, Hackney CVS increased our focus on adult safeguarding at the launch of the two year grants programme, ***A Place for Everyone***. Hackney CVS led an interactive session on the Care Act 2014, which was well received. In addition, each ***How to Apply*** funding workshop included an element of adult safeguarding.

In conclusion, Hackney CVS has actively supported the work of the CHSAB over the last year and provided the Board with the pathways to communicate their key messages to and to hear from the diverse voluntary & community sector. This was particularly significant in our extended work in facilitating community engagement in the CHSAB's strategic consultation.

We look forward to extending our work to include our new Safeguarding Community Engagement Forum, which now brings together selected key networks such as Hackney Refugee Forum, Health Watch Hackney, One Hackney, iCare, Connect Hackney, POHWER and the Health and Social Care Forum.

Healthwatch Hackney



Paul Fleming

Chair

Healthwatch Hackney exists to make local health and care services work and improve for the people who use them. We act as the independent champion for residents and people who use services locally by ensuring that the voices of people across the borough are heard in order to influence decision-makers. We do this by valuing diversity, encouraging participation and working together with statutory and non-statutory partners to ensure that treatment and care is provided with respect and dignity.

Hackney Healthwatch welcomed the move to place Safeguarding Adults Boards on a statutory footing under the Care Act this year. As a member of the CHSAB, we have worked to enable the partnership to develop and maintain effective local safeguarding arrangements by:

- Contributing to CHSAB and sub-group meetings, advocating for local people and speaking out on their behalf at a strategic level
- Promoting and commenting on the CHSAB's public consultation on its five-year strategy
- Undertaking six ***Enter & View*** visits in local health and social care services to see how care is provided and speak with people using the services
- For example, the findings from our visit to a local nursing home guided an unannounced CQC inspection and were used as evidence by the Health in Hackney Scrutiny Committee.
- Providing our views on the CHSAB's 2016/17 strategic plan
- Giving people the information they need to be able to identify and report issues to people who can help
- Promoting awareness about adult safeguarding to the communities that we engage with and to our staff
- Ensuring our staff and volunteers are trained in adult safeguarding
- Giving people the information they need to be able to identify and report issues to people who can help

Hackney Healthwatch will continue to support the CHSAB partnership to achieve its aim and objectives over the next year by ensuring that the voices of people across the borough are heard and influence services. Specifically, we will be monitoring the implementation of our Enter & View recommendations, contributing to overview and scrutiny work in the borough, and contributing to the CCG and Hackney Council's work programmes. We will also analyse our data about what people tell us so that we can identify emerging trends in people's experiences of services and raise frequently presenting concerns to the CCG and the Council.

NHS City and Hackney Clinical Commissioning Group

Julie Dalphinis

Adult Safeguarding Manager



1. What has your agency undertaken to meet the CHSAB Principles?

All National Health Service (NHS) bodies including City and Hackney Clinical Commissioning group (CHCCG) have a statutory duty to ensure that they make arrangements to safeguard and promote the welfare of adults and to protect those at risk from abuse.

Safeguarding individuals has remained a very high priority for both commissioners and providers of NHS services during 2015/16. City and Hackney Clinical Commissioning Group (the CCG) operates within the NHS Standard Contract. The wording in the Contract regarding safeguarding arrangements was strengthened in 2015/16. Specific requirements were included to comply with relevant law and updated guidance, along with clearer provisions on staff training and audit. A safeguarding Lead post has been introduced into the CCG structure to give greater capacity to meeting our safeguarding responsibilities.

The CCG's safeguarding, clinical and quality leads are up to date with their safeguarding training and where required have access to appropriate supervision. Safeguarding adults' training is part of the mandatory training programme for all staff employed by the CCG. Additionally, the CCG provided a lot of successful training to GP practice staff over the last year. The CCG provided Safeguarding Adults Training to 56 general practice clinical staff, including general practitioners and nurses. Practice staff also attended a face-to-face update and 112 completed an e-learning module which the CCG had commissioned for non-clinical staff. This was done under the expectation that learning will be cascaded to the other clinical members of staff within the practice following their attendance of the face to face training session. Notes and case studies from the course are available on the CCG website and slides from previous Mental Capacity training are also available there too. The Clinical Lead for Adult Safeguarding also provided training to GPs working in the 'Out of Hours' service at City and Hackney Urgent Healthcare Social Enterprise.

2. What difference has your agency made to improve the safeguarding of adults and promote their welfare?

The CCG is a membership organisation comprised of 43 General Practices arranged in 6 consortia. Its purpose is to commission health services for both the registered and unregistered populations who live in the geographical area.

The CCG operates under the NHS England 2015 Safeguarding Vulnerable

People in the NHS policy which sets out the statutory requirements for the NHS to discharge its accountability for safeguarding adults at risk of harm or abuse. The policy sets out the safeguarding roles, duties and responsibilities of all organisations in the NHS. It has been developed by NHS England in partnership with colleagues from across the health and social care system, the Department of Health (DH) and the Department for Education (DfE).

The CCG has revised its policy for adult and children's safeguarding over the past year in order to ensure that they comply with upgraded national statutory requirements as well the newly published London Multi-Agency Adult Safeguarding Policy & Procedures. They are based on the principles, legislative requirements and contractual expectations of adult safeguarding to safeguard and promote the well-being of adults with needs for care and support. The CCG's responsibility for safeguarding demands that the following aspects of safeguarding governance and commissioning responsibility are in place:

- a) Clear lines of accountability for the safe commissioning and delivery of services
- b) Ensuring that safeguarding expertise is embedded in the clinical decision-making of the CCG
- c) Working to develop safeguarding supervision
- d) Representation at the CHSAB and its sub-groups
- e) Ensuring that contracted services are delivered safely and in line with section 32 of the NHS Standard contract and the law
- f) Working to implement robust governance procedures for contract monitoring and quality assurance
- g) Engaging in peer reviews of safeguarding processes and using the results to improve safeguarding adults practice
- h) Using learning effectively following SARs and Domestic Homicide Reviews

The following roles are in place in order to ensure that the CCG can fulfil its duties.

1. The CCG Chair is the executive Lead for safeguarding adults for the organisation. The Vice Chair is the executive Mental Capacity Act Lead.
2. A Lead for Adult Safeguarding, a GP Clinical Learning Lead for Adult Safeguarding and a Lead for Mental Capacity.
3. The Adult Safeguarding Manager is the Prevent Lead and reports to the Head of Quality.
4. There is effective inter-agency working with the London Borough of

Hackney and the City of London Corporation, with clear membership of the safeguarding boards and associated sub-committee and sub-groups.

5. The CCG complies with the national statutory requirements and London procedures for safeguarding adults in its commissioning. The CCG commissioning policies are being reworked in relation to regional and national safeguarding changes and were submitted for approval to the CCG safeguarding group.
6. Safeguarding adults training is part of the mandatory training programme for all staff employed by the CCG.

3. How does your agency evaluate its effectiveness and what evidence do you have?

1. The CCG has been assured by the NHS England Safeguarding Adults at Risk Audit Tool 2015/16 that its systems of risk assessments and identification to stop concerns escalating are “good”.
2. During the past year the CCG has updated its safeguarding adults policy which will support the CCG in achieving compliance with commissioning under the auspices of the Care Act.
3. The CCG has developed serious incident management processes in relation to safeguarding which have improved safety and governance. The CCG has also developed partnership working around serious incident reviews.
4. The CCG has developed its contractual specifications to include adult safeguarding.
5. Recent Domestic Homicide Reviews in Hackney highlighted poor communication of information between the Multi-Agency Risk Assessment Conference (MARAC) and GPs, which can potentially have a negative impact on the aim to reduce domestic violence and protect those at high risk of domestic violence and abuse. As a result, the CCG has funded a new post to support the Multi Agency Risk Assessment Conference (MARAC). This nurse-led service aims to address this gap and ensure a safer plan for victims of abuse as well as ensuring that the GP is aware of both the risks and the safety plan agreed at the conference. This has been commended by NHS England.
6. The CCG is on track to meet the national Prevent compliance standard of 100% by 2018. The CCG has a Prevent duty to work to prevent people from being drawn into terrorism. This duty requires the CCG, and providers of NHS services, to ensure that their staff are trained to be competent in identifying and responding appropriately to any suspected radicalisation. This is a requirement in the contracts for 2016-17 and NHS Trusts will provide assurance on this to the CCG. These actions are audited by NHS England and ultimately the Home Office on a quarterly basis.

4. How has your agency challenged itself and others to improve safeguarding arrangements? What were the risks and impact of your challenge?

The CCG has challenged itself and others to improve safeguarding arrangements variously:

- The CCG has endeavoured to ensure that safeguarding training is up to date over the past year. The recent NHS England audit has shown that the CCG is 80% compliant with this. There is a compliance rate of 80% within the provider Trusts.
- The CCG has endeavoured to ensure that it learns from Safeguarding Adults Reviews (SARs). The CCG has engaged in three SARs instigated by the CHSAB over the past year, with the Adult Safeguarding Manager and the GP Clinical Learning Lead acting as SAR panel members. This representation has enabled the CCG to support the Board in its statutory duties and help the CCG to address the challenge of enabling SAR learning to be embedded across the health economy. The learning from the Reviews is shared with the CCG and the learning from each case will also be disseminated to practices where relevant.
- The CCG has also endeavoured to ensure that it supports and learns from Domestic Homicide Reviews and one such Review is currently underway in the City of London. The Adult Safeguarding Manager represented the CCG on this Review panel as well. The learning from this review will be shared with the relevant CCG Committees and Providers and the safeguarding group once the Review is complete.
- The Winterbourne View scandal in 2011 led to a Department of Health pledge to move all people with learning disabilities and/or autism who were placed in institutions to community placements by the end of March 2015. The CCG endeavoured to review safeguarding arrangements and to move people from these institutions and this was achieved in City and Hackney (although it was considered that two people were not appropriately placed because of their complex histories).
- The CCG has adopted the new London Multi-Agency Adult Safeguarding Policy & Procedures and has endeavoured to revise its policies that include adult safeguarding. Most of this work has been completed. Similarly, work to review the CCG Contracts so that they include safeguarding elements as per the NHS Contract section 32 has also been completed. Further work is needed on updating the policies for safe recruitment, whistleblowing and on managing allegations against people who work with the adult public.
- The CCG has updated its website to include information on adult safeguarding.

- The CCG will receive regular monitoring reports from providers on adult safeguarding within their services including evidence of training compliance. There will be joint work on the locality safeguarding dashboard and reporting template. The CCG will ensure attendance and contribution at learning events and a Training Needs Analysis will be undertaken with a view to developing appropriate training and ensuring that training levels are reported quarterly to the CCG.
- The CCG aims to provide Prevent training to GP Practices this coming year and there will be a further Safeguarding Adults training course delivered later in the year for GP staff. We will also be arranging a teaching session for GP Registrars this year to ensure safeguarding adults training is embedded in GP training in the City and Hackney.

Homerton University Hospital NHS Foundation Trust



Lesley Rogers

Head of Healthcare Compliance

1. What has your agency undertaken to meet the CHSAB Principles?

All our learning will be shared learning

The skill base of our staff will be continuously improving

Close working between the Homerton Safeguarding Adults and Safeguarding Children committees continued during 2015/16, via the quarterly joint meetings of the committees. These were chaired by the Trust Chief Nurse who is the Trust's Executive Lead for Safeguarding.

The safeguarding committees work to six shared principles, one of which relates to shared learning: *'Effective and appropriate training for all, underpinned by lifelong learning, learning from incidents and training models that demonstrably improve competence and confidence'*. In line with this principle and the implementation of the Care Act from the 1 April 2015, the content of the safeguarding adults training sessions at level 1 (undertaken by all Trust staff at induction) and level 2 (all clinical staff working with adults) was completely revised and re-shaped. The revisions were informed by the draft Intercollegiate Document on the roles and competencies for health care staff on safeguarding adults. The content and modes for delivery of training have also been informed by feedback both from over 70 staff across the Trust's acute and community based services and from different disciplines who were involved in testing a new module for reporting safeguarding incidents and disclosures.

The average uptake of safeguarding adults level 1 training during 2015/16 remained high, with 96% of staff completing the training. The percentage of staff eligible to be trained at level 2 who completed training increased steadily during the year from 40% to 51.5%, despite the substantial gaps in capacity in the corporate safeguarding adults team due to long term sickness absence and staff vacancy.

A key priority for 2016/17 is the roll out of a safeguarding adults level 2 e-learning course which incorporates test questions to assess competence. This e-learning course will be supplemented with face-to-face training sessions tailored to each service and using safeguarding adults case studies drawn from safeguarding incidents and disclosures, as well as the CHSAB Safeguarding Adults Reviews.

Prevent has been a standing item for discussion and action by the joint meetings of the Safeguarding Committees. Prevent awareness training was

incorporated into both safeguarding adults and children level 1 and 2 training. The challenge of delivering WRAP (Workshop Raising Awareness of Prevent) training in the manner prescribed by the Government remains and will be a focus for action in 2016/17.

Close working between specialist practitioners in dementia and learning disability and the safeguarding adults team with staff in the clinical services continued in 2015/16. For example, in October we held a workshop on the Mental Capacity Act and Deprivation of Liberty Safeguards aimed at medical consultants, chaired by the trust Medical Director. The workshop included contributions from Bevan Brittan solicitors on the Law Commission's consultation on Mental Capacity legislation. Action following the workshop has included designing a better system for recording mental capacity assessments as part of the hospital electronic patient record. This will be further tested and fully implemented during 2016/17.

We will promote a fair and open culture

All staff at Homerton have a duty to **recognise, report** and **act** on safeguarding disclosures to ensure that patients and clients, whether adults or children, are protected. In common with many NHS organisations, the Datix incident reporting system is used to report incidents and disclosures throughout the Trust's acute and community based services. However, safeguarding children and adults practitioners raised concerns about deficiencies in the capture and accuracy of safeguarding incidents reported via Datix. In line with Don Berwick's statement, to make *improvements requires a system of support*, the heads of the safeguarding children and safeguarding adults teams set out to improve the quality of safeguarding by developing a better system for the reporting of safeguarding concerns. It was reasoned that the development of the system on Datix would also foster an open culture in reporting safeguarding concerns in the same way as other incidents.

The safeguarding module comprises a small number of questions which both elicit key information from staff reporting a safeguarding incident or disclosure and prompt staff to take follow-up action. Appropriate action includes referring a safeguarding adult concern to the local authority where necessary. The module was implemented in March 2016 and initial results have been very positive, including:

- **Improved accuracy** of reporting of safeguarding adult incidents and disclosures
- **Improved timeliness of response** to safeguarding adult incidents
- **Datix system** supports thematic analysis of safeguarding adult's incidents
- **Structured review of incidents** with a decision-tree to follow up incidents and feedback to reporters
- **Improved training of Trust staff** with specific details on reporting
- **Bespoke training** session delivered to corporate safety/risk staff to improve their knowledge and awareness of safeguarding

We will understand the complexity of local safeguarding needs

The safeguarding adults team has used the development of the improved system of reporting safeguarding concerns to identify themes and issues to help the organisation and the CHSAB to understand the complexity of the needs of local communities. Analysis of incidents and disclosures in 2014/15 revealed that 'Neglect', including self-neglect, was the harm most often identified in adult safeguarding cases. Homerton staff played an active role in contributing to the development of the CHSAB multi-agency Self-Neglect protocol, bringing expertise and knowledge from across acute and community based services. We have raised awareness of the protocol, including via safeguarding adults level 2 training and case-based update training in specific services, such as the Emergency Department.

2. What difference has your agency made to improve the safeguarding of adults and in promoting their welfare?

A Quality Account is a report about the quality of services by an NHS healthcare provider. These reports are published annually and are publicly available. For the first time the safeguarding adult team set a priority in the Quality Account for 2015/16. We wanted to raise the profile of the 'Empowerment' principle in safeguarding adults and link this to 'Making Safeguarding Personal'.

The objective was: to 'Make Safeguarding Adults Personal' by capturing the views and wishes of patients and clients on the outcome of the safeguarding adults process'. We used the re-design of the safeguarding adults training materials as an opportunity to include a case study to illustrate the concept of 'Making Safeguarding Personal'. Staff were also prompted to find out and record the outcome the adult at risk wanted from the safeguarding process when referring safeguarding concern to the local authority. Our target was to ensure that 25% of all safeguarding adult referrals include 'Making Safeguarding Personal' information. On average, from July 2015 to March 2016, 23% of referrals met the target.

We aim to improve this practice in 2016/17 through the implementation of the improved safeguarding reporting system as well as improved uptake of training.

Homerton has also continued to protect adult patients and clients by providing safe clinical care, particularly through monitoring of 'Harm free care' via the 'National Safety Thermometer' which is a nationally recognised tool. The 'National Safety Thermometer' programme, involves the collection of data on patients in relation to potential harms. It is a 'point prevalence survey' (that is the number of harms seen at a particular point in time) and can be used to show trends in the number of harms suffered as an indicator of the safety of patients over time. Data are collected and entered into the safety thermometer software and uploaded to a national portal. Every patient being cared for is assessed for four specific areas of harm: pressure ulcers, falls

that cause harm, urine infections in patients with a catheter, and venous thromboembolism (the formation of blood clots in the vein). This provides a snapshot of the level of harm-free care. During the time period April 2015 to March 2016, Homerton provided care that was consistently better, that is higher levels of harm free care, than the national average.

3. How does your agency evaluate its effectiveness and what evidence do you have?

The Homerton Safeguarding Adults Committee held quarterly meetings during 2015/16 to monitor the effectiveness of action to safeguard patients and clients using national or regionally developed tools wherever possible. Examples include the continued use of the NHS England Safeguarding Adults at Risk Framework (SAAF) to assess, track and revise the work plans of the safeguarding adults team and associated staff and services. Unfortunately, the absence of a full complement of safeguarding adult team members for over 80% of the time period meant that the maintenance of an effective service to support staff in direct contact with patients and clients was challenging. Maintaining and improving the skills and knowledge of these staff was a key focus in these circumstances. Nevertheless, during 2015/16, 64% of the 14 SAAF elements were scored green, meaning the requirement is met consistently across the organisation. 36% were scored yellow, meaning the requirement is partly met.

The Committee also evaluated how the Trust complies with the revised London Multi-Agency Adult Safeguarding Policy & Procedures 2015. This confirmed that the Trust complies with the policy & procedures and the recommendations for minor action needed to embed the best practice form part of the safeguarding adults team work plan for 2016/17.

4. How has your agency challenged itself and others to improve safeguarding arrangements? What were the risks and impact of your challenge?

The Trust has been committed to meeting the recommendations in the Lampard Report into NHS investigations into matters relating to Jimmy Savile, published in 2015. This has included working with diverse communities such as the Charedi Orthodox Jewish community to ensure that organisations that provide services and people who volunteer across the Trust comply with the recommendations set out in the Lampard report and the Department of Health response to the report. The Safeguarding Adults and Children teams together with the Head of Patient Experience and the Volunteer Coordinator worked closely with groups across Hackney's communities. A pragmatic and enabling approach was taken which ensured that individuals keen to volunteer their services became part of the official 'Homerton Helpers' scheme. This has ensured that the Trust maintained its commitment to being inclusive whilst acting in line with the Lampard Report. The progress with meeting the Lampard recommendations have been monitored regularly and reported on to the City and Hackney Clinical Commissioning Group safeguarding managers.

Case Study

Making a difference: carer abuse

The victim is a 57 year old female who lives with Alzheimer's and severe communication difficulties. An allegation was made to the police that her care providers had placed her into a hot bath resulting in 20% first degree burns to her legs and arms and causing scolding and burns to her body.

A police investigation commenced with close liaison with care provider, CQC and Adult Social Care in attendance at strategy meetings. The carer was arrested and interviewed. The case has been referred to the CPS and their charging decision is awaited.

East London NHS Foundation Trust



Janet Boorman

Associate Director for Safeguarding Adults & Domestic Violence

1. What has your agency undertaken to meet the SAB Principles?

All our learning will be shared learning

This year the safeguarding adults team have been attending team meetings and group supervision sessions to promote learning from cases. These have been from other local authority areas as well as within Hackney. The most notable has been learning from the draft report of the Mrs A & Mr B Safeguarding Adults Review. This prompted specific training for staff about sexuality and staff responses to risks within the services for older people.

We will promote a fair and open culture

The Associate Directors held a workshop for the Trust's Board members to look at the implications for Trust's services following the implementation of the Care Act. The workshop included both Executive and Non-Executive Directors and emphasised the importance of their role in promoting good safeguarding practice within the organisation from the top-down. Learning Lessons seminars are arranged for significant events and Reflective sessions are held routinely for teams where there has been a local incident for staff to have the opportunity to share their thoughts and promote good team work for the future.

We will understand the complexity of local safeguarding needs

The Trust is aware that safeguarding is a broad umbrella term which incorporates all forms of patient safety from preventative practice to appropriate responses to allegations or incidents. An example is the increasing use by staff of routine enquiry about abuse following training. Support is also arranged when staff disclose when they are at risk of domestic violence in their own personal lives.

The skill base of our staff will be continuously improving

The Trust is very aware of the duty to provide safeguarding training that meets the needs of the various staff in different positions across all services. The training reflects the new definitions of safeguarding or abuse concerns set out in the Care Act's statutory guidance (such as modern day slavery, domestic abuse and self-neglect) using case examples. There has always been an emphasis on encouraging staff within operational services to assist in presenting the training programme and this has ensured that the programme is kept up to date with recent changes in local practice.

2. What difference has your agency made to improve the safeguarding of adults and promote their welfare?

The Trust has a dedicated safeguarding adults team that takes responsibility for ensuring that there is Level 1 & 2 training for all new staff which covers awareness of domestic violence and the Prevent agenda. In addition to speaking to their manager, staff may contact the team for support and advice. Over time contacts have been about how to prevent abuse as well as responding to allegations of abuse and neglect by using the safeguarding procedures.

3. How does your agency evaluate its effectiveness and what evidence do you have?

The Trust has a Safeguarding Adults Committee that meets bi-monthly where a quarterly data and analysis report is shared for Assurance purposes about the process and the outcomes of safeguarding incidents that have occurred.

4. How has your agency challenged itself and others to improve safeguarding arrangements? What were the risks and impact of your challenge?

Implementing the Prevent agenda was a challenge this year, given its potential for controversy both publicly and within services. The Trust sought and received NHS England funding to develop an innovative WRAP session followed by actor-led scenarios. These were well received giving the staff a chance to ask questions in a safe environment and to develop their skills and confidence in this area. This will also become available in the coming year as an e-learning refresher training for all staff, showing the possible outcomes for referrals to the Channel Panel for two very different concerns about people who use services who are at risk of radicalisation to violent extremism.

Barts Health NHS Trust

Jane Callaghan

Head of Safeguarding Adults



1. What has your agency undertaken to meet the CHSAB Principles?

One of our main objectives this year was to establish sound practice in relation to application of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), which encompasses a number of the safeguarding principles.

We established and met the following milestones in respect of leadership, training, awareness raising, completion of capacity assessments and completion of DoLS applications.

1. Provide assurance that there is sufficient safeguarding/MCA DoLS leadership (including the establishment of MCA-DoLS champions) to support MCA and DoLS

Despite some recruitment/retention issues in the Safeguarding team, the completion of a Commissioning for Quality & Innovation scheme demonstrates that the leadership has been in place. MCA-DoLS Champions have been recruited, trained, and have contributed to this work.

2. Raise the profile and understanding by implementing an Awareness Week within the trust

This was held successfully in November 2015, see below.

3. Develop awareness and understanding by training and educating the workforce

Training targets were set as required by the CQUin, and have been exceeded.

4. Evaluate how embedded MCA-DoLS is in clinical practice

A paper summarising progress was presented. CQC data suggests that DoLS is more embedded in Barts Health NHS Trust than any other Trust, by a wide margin.

5. Increase the number of capacity assessments by 30%

This has been achieved. (Baseline audit: 24%. Final audit: 76%.)

6. Ensure that a DoLS application is made for 95% of eligible patients

This has been achieved. (Baseline audit: 73%. Final audit: 97%.)

The MCA Awareness Week took place from 23 November to 1 December 2015. It included the implementation of a Trust-wide screensaver promoting the 5 key principles of the MCA, distribution of mouse mats featuring the key principles of the MCA, canteen-based stalls held over lunch time in each of our hospital sites, and distributing information about DoLS and MCA in various formats, including posters, leaflets and information sheets. Stalls were manned by members of the Safeguarding team, advertised by conspicuous banners and balloons and a range of other media, such as pens, mouse mats, competitions, and sweets, to encourage staff and visitors to come to visit the stall. 307 staff visited the stalls, 500 mouse mats were distributed and 150 posters and 500 leaflets were taken. A high-level open lecture on legal issues relating to DoLS was delivered by a partner from the Trust's external solicitors, which was attended by 91 people. 750 DoLS/MCA-focused prize crosswords in which all the answers could be found by reading a summary article on DoLS were distributed, with 32 completed. There were also additional open teaching sessions on MCA alongside the implementation of an on-line DoLS-MCA competency assessment to complement the training. 28 staff completed the assessment. Study materials relating to the week, including an interview with the Safeguarding Team MCA-DoLS lead, were published on the intranet. Additionally, a "Capacity to Consent to Admission and Treatment" form for all admitted adult patients was distributed to all sites during the week.

2. What difference has your agency made to improve the safeguarding of adults and promote their welfare?

The Trust has unique challenges in meeting the needs of very different and diverse communities. The Care Act 2014 has put safeguarding adults on a statutory footing, where robust governance arrangements and assurance are required for an expanded safeguarding adult agenda. The Cheshire West ruling on Deprivation of Liberties Safeguards (DoLS) has also had a significant impact on our work. The recent CQC inspections at Barts Health NHS Trust identified that safeguarding adult arrangements were in place and were followed in most circumstances. Staff were compassionate and respected patients' dignity. However, there were some areas that needed to be strengthened and we undertook to:

- Ensure that there are robust systems in place to protect adults at risk in all clinical areas
- Embed the principles of the Mental Capacity Act in practice

Recruitment to temporary posts to support improvement work in safeguarding was partially successful. The small safeguarding team has undertaken to attend safety 'huddles', visit wards and support safeguarding strategy meetings and investigations across the Trust. A model for an expanded safeguarding adult's team has been developed in line with both what staff told us was needed through a commissioned external review of safeguarding arrangements (see below) and the operating models in other Trusts. The new

model, which incorporates a safeguarding advisor for each of the hospital sites, requires approximately £300,000 investment and this will be considered with other cost pressures as part of the budget-setting exercise in March 2016.

3. How does your agency evaluate its effectiveness and what evidence do you have?

We commissioned an external review of safeguarding arrangements throughout the Trust in July 2015. The report and recommendations formed the agenda of a summit where staff and partners worked together to agree the safeguarding model for Barts Health NHS Trust. An integrated strategy for safeguarding adults and children that will describe that model is in development and this will be circulated for consultation during March 2016. The strategy will outline the governance, assurance and leadership expectations for both safeguarding adults and children.

A set of metrics have been developed and agreed with the Local Authorities to monitor safeguarding activity. Each hospital Director of Nursing receives monthly reports on these metrics, which include training compliance. The terms of reference for hospital-based operational safeguarding meetings have been agreed practice and improve the assurance of safeguarding arrangements.

4. How has your agency challenged itself and others to improve safeguarding arrangements? What were the risks and impact of your challenge?

One of the key challenges for our staff has been through competency assessments undertaken with registered nurses in inpatient areas in our hospitals. There were gaps in the knowledge of staff about the types of abuse that may happen in hospital and some responded to questions about safeguarding by deferring to either senior nurses or doctors who they expected to take responsibility and tell them what to do. Some staff did not demonstrate knowledge and practice commensurate with statutory training. This gap has been challenged through safety 'huddles' and sister's meetings, face-to-face training on the preceptorship, internationally trained nurse programmes, and a number of face-to-face, bespoke training sessions on site, including as study days for surgical nurses. However, it is clear that a robust competency-based training strategy is needed. Work with the Education Academy is being undertaken to inform a business plan that puts safeguarding adults training, in line with the Care Act, on the same footing as safeguarding children.

This will include face-to-face competency based training for all registered health professionals at band 6 or above on induction, which will be updated every 3 years; enhanced training for senior leaders and those who give advice to others about responding to safeguarding concerns and updated, enhanced content for level 2 training for all staff.

Metropolitan Police



Cath Edgington

Detective Chief Inspector, Hackney Borough
Reactive & Public Protection Unit

1. What has your agency undertaken to meet the SAB Principles?

The London position for Safeguarding Adults within the Metropolitan Police Service (MPS) has changed significantly over the last few years. Historically, different policies, procedures and referring processes were operating across the 32 Boroughs, none of which were recordable or searchable. This has now change as new processes, toolkits and pathways have been implemented and consolidated through increased partnership working across the MPS.

The MPS has a duty to work in partnership to protect the most vulnerable persons in society. Like many other public authorities, the police frequently continue to be the first point of contact for a vulnerable person in crisis. It is recognised that front line officers need to be able to identify vulnerability and risk and seek early intervention opportunities to support and protect the vulnerable within the community. The MPS uses the following definitions:

Vulnerable Adult:

A person aged 18 years or over who is or may be at risk of abuse by reasons of Mental or other disability, age or illness and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.

Vulnerable Adult Abuse:

A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust (which can include a relative, carer or service provider) which causes harm or distress to a vulnerable adult.

The MPS record encounters with vulnerable adults who come to the attention of police whether as a victim, witness, suspect or member of the public. These are recorded on the Merlin system as Adult Coming to Notice (CAN) events. Merlin records are completed in the following circumstances where:

- a) There is a concern of vulnerability in one or more of the following aspects:
 - i. Physical
 - ii. Emotional/Psychological
 - iii. Sexual
 - iv. Acts of Omission / Neglect
 - v. Financial

and

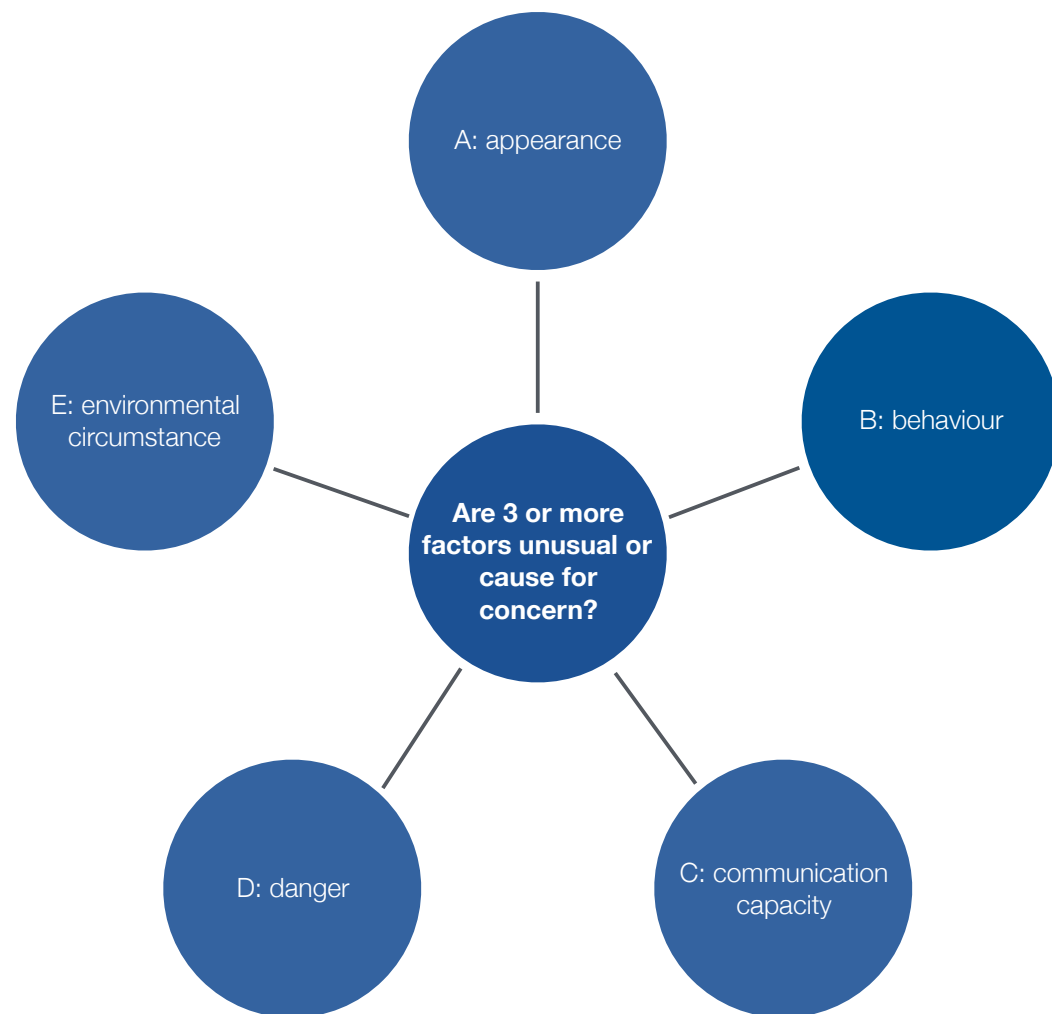
- b) There a risk of harm to that person or another person

Those who come to the notice of the police as vulnerable will require an appropriate response which may include a multi-agency intervention.

MPS Hackney recognises the six statutory principles of Adult Safeguarding and works towards these throughout all stages of our involvement with a Vulnerable Adult or adult at risk - from initial contact and identification of vulnerability, during the investigation and referral process, with intervention opportunities, in seeking the consent of the person, and in information-sharing and record making.

When coming into contact with a member of the public as a victim, witness or suspect, all MPS personnel must carry out a Vulnerability Assessment Framework (VAF) assessment to identify any vulnerability. The use of this assessment at the earliest possible stage maximises early intervention opportunities and helps prevent victimisation.

Vulnerability Assessment Framework (VAF)

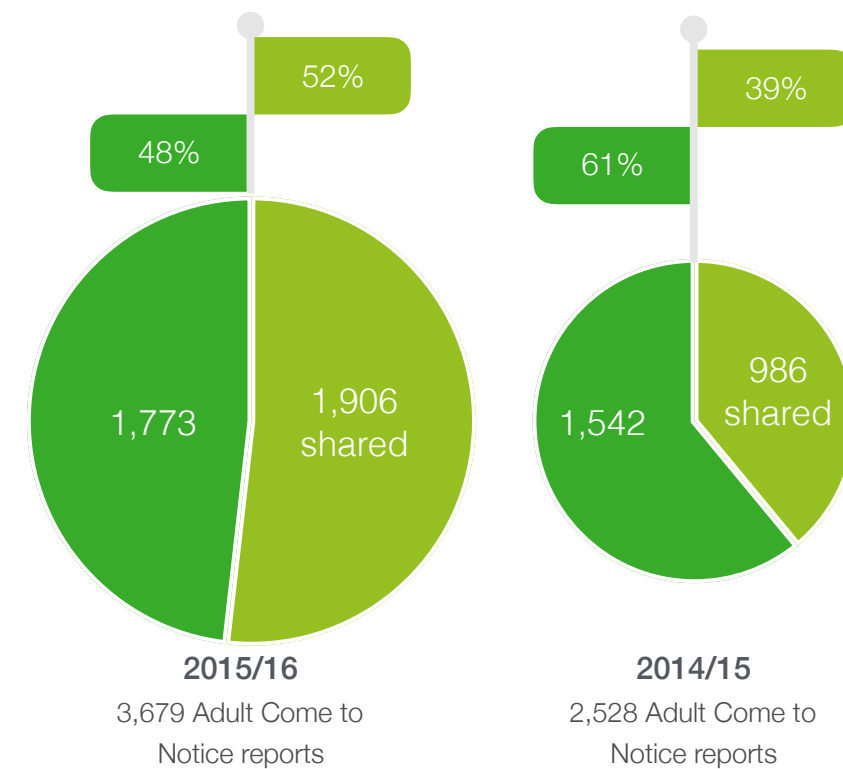


When three or more of the five VAF areas are identified a Merlin report is created (and a Crime Report if a crime is alleged).

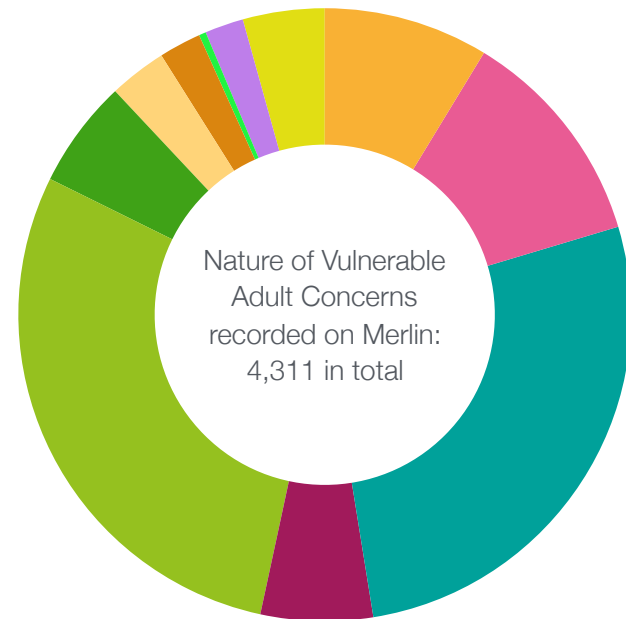
If fewer than three VAF areas are identified while there is a cause for concern for the person then an Adult Come to Notice (ACN) is created.

The officer ensures the reason for the creation of an ACN is recorded in all cases, together with the person's views regarding any consent for any referral issue. All vulnerability reports are reviewed by staff within our Public Protection Unit and any linked crime investigations are investigated by our Safeguarding Adult Detective officers located within the Community Safety Unit at Stoke Newington Police Station.

Between April 2015 to April 2016 there have been 3,679 recorded Adult Come to Notice reports for Hackney residents. 1,906 (52 %) have been shared with partner agencies, an increase on the 39% share rate from April 2014 to April 2015 (986 shared out of 2528 cases).



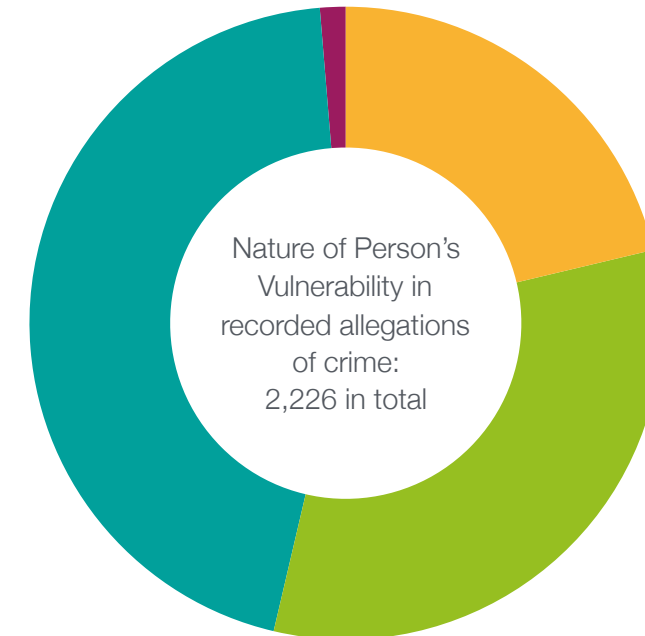
Concerns raised by officers on Vulnerable Adult Merlins can be subjective and many reports will show multiple concerns as shown below.



- Adult Risk of Harm due to Age: 375
- Adult Risk of Harm due to Disability: 503
- Adult Welfare Concerns (non specific) : 1,168
- Alzheimer's / Dementia : 255
- Mental health crises: 1,247
- Mental health – Voluntarily to hospital: 246
- Sec 136 Mental Health Act : 131
- Sec 135 Mental Health Act : 96
- Mental Capacity Act : 16
- Domestic Abuse: 88
- Victim of Crime : 186

Crime Investigation

There are two Adult Safeguarding Detectives within the Community Safety Unit who investigate allegations of crime against Vulnerable Adults by someone who is a family member or in another caring capacity. These are reports, incidents or contacts with police that result in a crime report being raised.



- Mental Health Impairment / vulnerability: 552
- Physical Impairment / vulnerability: 840
- Intimidated Victim: 840
- Vulnerable Adult Abuse Flag

It should be noted that not all Crime reports involve a criminal offence taking place. Some reports are raised when events are unclear or to assist with risk management and supervision, where a non-crime incident takes place within a domestic setting, for example. In such a case a Non-Crime Domestic report is raised, which is reviewed by a Detective from the Community Safety Unit to ensure that risk is managed and support provided and no crimes missed by a reporting officer who does not have the specialist training.

Case Study

Making a difference: a non-domestic crime incident

Concerns were reported by family members that a sibling had been taking advantage of their elderly mother who was living with dementia. There was a concern that the sibling had dishonestly taken over management of the mother's finances for their own gain. The elderly mother was clear that she did not want the alleged perpetrator arrested. Officers undertook a full investigation, obtained statements, attended strategy meeting with the Safeguarding Adults Team and worked with partner agencies and an Independent Domestic Violence Advisor to support the victim at court for an Occupation Order against the perpetrator.

The police will, where appropriate, be the lead agency in criminal cases, but it is essential that we work closely with the local authority and other partner agencies to ensure that evidence is gathered, relevant information is shared, risk is identified and managed and a safeguarding plan is agreed at an early stage.

Where necessary the police will interview the alleged victim (who may well need support and/or communication aids or special support measures), the alleged perpetrator and witnesses.

In cases where criminal proceedings are not pursued following a decision by the Crown Prosecution Service, the police will agree with partners a course of action with partnership agencies to protect the adult(s) concerned.

Local training ensures that officers, particularly those dealing directly with Vulnerable Adult investigations, are kept up to date with their legal powers and duties, including their responsibilities in relation to the Mental Capacity Act and Mental Health Act.

2. What difference has your agency made to improve the safeguarding of adults and promote their welfare?

Working with Partner Agencies

The MPS has a statutory duty to safeguard Vulnerable Adults and those at risk and a statutory duty to co-operate with our partners. We do this through:

Safeguarding Adult Board membership and engagement:

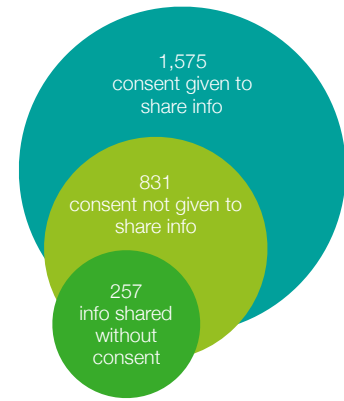
DCI lead for Public Protection is a core member of the CHSAB, attending full, Executive Group and sub-group meetings.

The police Designated Adult Safeguarding Manager (DASM):

This is an officer with sound knowledge of multi-agency working and adults at risk investigations. This role is currently held by the Borough CSU DI as they have the remit for most safeguarding adult investigations and responsible for the management and oversight of individual, complex cases where allegations are made or concerns raised about a person in a position of trust whether an employee, volunteer or student, paid or unpaid acting for the partner agency. The police DASM provides expertise, advice and guidance and liaises with partner agencies as necessary. This involves ensuring the progression of cases to ensure they are conducted in timely manner.

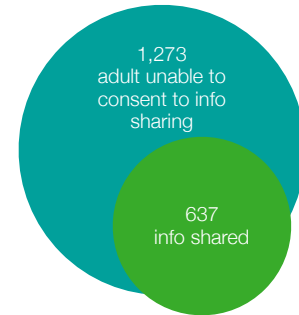
Information Sharing:

This is a key role for MPS Hackney and the Public Protection Unit. Information-Sharing Agreements enable police to comply with their duty to protect adults from abuse and neglect, bring perpetrators to justice and provide relevant information with and without consent.



MPS officers seek the adult's consent to share:
 Consent to share was given in 1,575 cases (64%) with Consent Not Given in 31% of cases (831) and in 31% of cases where consent not given the concern was shared with the consent refusal being overridden.

In 1,273 cases, the Adult was unable to give consent of which 50% shared without recorded consent.



Hackney Community MARAC

The Community MARAC is a recent addition to Hackney's multi-agency response to the management of High Risk Vulnerable Adults. Hackney MPS have played an active role in the working group and are core members on the MARAC panel, where information is shared on complex/high risk cases between various stakeholders. The primary focus of the panel is to put a plan into place to safeguard victims, witnesses, and suspects where appropriate, to prevent further victimisation or criminal activity.

Where legislation and information sharing protocols allow, all relevant information is shared about victims, witnesses and perpetrators, the representatives then discuss options for increasing the safety and or wellbeing of the victims, suspects and/or witnesses and, if relevant, addressing the perpetrator's behaviour, turning these into a co-ordinated action plan. In some cases, while there is no criminal aspect, the person may have come to police notice as there are concerns that the individual is becoming increasingly vulnerable and would benefit from partnership support or intervention.

Safeguarding Adults Reviews & Individual Management Reports:

MPS Hackney engage as a member of the CHSAB's SAR & Case Review sub-group and were a contributing agency to one of the SARs instigated by the Board this year.

3. How does your agency evaluate its effectiveness and what evidence do you have?

Assessing effectiveness of MPS work in this area requires further work.

There has been an additional 1,151 Merlins created for the period April 2015 to April 2016, compared to the previous year with an increase of 13% in Information sharing amongst Partner Agencies. The year-on-year increase in ACN Merlin reports indicates that front line officers are better able to recognise, record and refer Vulnerable Adults and Adults at risk.

This year has seen the introduction of two dedicated Vulnerable Adult Crime Investigators with specific focus on Vulnerable Adult Abuse and Carer Abuse. Their development of specialist skills and partner relationships with professionals in Adult Safeguarding has had a positive impact for victims of crime.

However, specialist data research needs to be commissioned as there is no corporate data with sufficient levels of detail to evaluate the effectiveness of the MPS and MPS Hackney in respect of our involvement with Vulnerable Adults or adults at risk.

4. How has your agency challenged itself and others to improve safeguarding arrangements? What were the risks and impact of your challenge?

The current MPS policy for Safeguarding Vulnerable Adults seeks to professionalise and improve the quality of service delivery to adults at risk who are or suspected of being the victims of abuse and crime. It has provided a standardised approach across the MPS to the identification and management of Vulnerability and the Protection of Adults at Risk incidents by issuing clear instructions to staff ensuring that everyone understands their roles and responsibilities.

The policy also seeks to develop good practice relating to the prevention and detection of crime. It will ensure that the MPS is legally compliant and is intended to increase the level of reporting, prosecution and monitoring of vulnerability and adult at risk cases.

Furthermore, the policy's aim is to improve the response to Vulnerability adult at risk incidents, risk assessment and management of cases, leading to the improved safety of victims.

The MPS recognises that there are complexities to the police role in upholding the CHSAB principles. For example, positive action may require the arrest of a perpetrator against the expressed wishes of the adult at risk.

The MPS also recognises that people can experience other barriers to reporting and investigation:

- **Fear of detrimental outcomes:** Of being placed in institutional care setting rather than at home, for example. There may also be a reluctance to report safeguarding concerns to police out of a fear of bringing shame to the family's honour.
- **Lack of mental capacity:** Vulnerable Adults may be unable to make a decision about how to keep themselves safe at a time when it is needed.

In situations where adults at risk choose to live in risky situations there remains a duty of care by all agencies involved with the adult to take appropriate and proportionate action to minimise the risks involved. The views of the adult at risk should be sought and should form the basis of the risk assessment. Many professional, doctors and social workers, for example, cannot take decisions affecting adults with capacity, without their consent. Police officers are not similarly limited. When acting in the public interest or applying the criminal law, the police may make decisions about a person without their consent. This includes making referrals to Adult Social Care and necessarily sharing restricted information with our statutory partners.

- **Failing to obtain an account directly from the adult at risk:** Police need to speak to the adult at risk and secure other evidence and information from as many sources as possible. This will maximise opportunities for a successful outcome.
- **Failing to assess risk:** Police must make a determination of the risk of harm to the person or to another. The views of the adult at risk are sought and they form the basis of the risk assessment. We ensure all views and decisions are documented on the Merlin and CRIS.
- **Failing to obtain access to the adult at risk:** There is no basis in law for removing an adult to a place of safety unless section 136 Mental Health Act (MHA) 1983 applies. This action, therefore, can only be carried out with the person's consent, or where the adult lacks capacity in accordance with the Mental Capacity Act 2005 best interest principles.
- **Assumptions/prejudices towards adults at risk:** Training assists our officers to break down this barrier and not to make judgments as to whether a witness is likely to be accepted as competent by the courts. Officers should not make assumptions based on the vulnerability of the victim. For example, repeated calls received from an adult placed in a mental health setting who is alleging they have been assaulted by other service users or staff should be visited, despite possible doubts about their credibility.

Historically, adults at risk or with care and support needs have been treated as second class citizens, either as active citizens within society or through discrimination by criminal justice services. This prejudicial treatment is

based on false perceptions as to how people's needs or conditions make them vulnerable, rather than the actions of others. The purpose of current government and MPS policy is to confer the balance of belief and credibility back to adults at risk through ensuring that those in the position to listen and assist do so, without prejudice. It is important that the MPS does not use someone's perceived vulnerability - which may make them appear less capable - inadvertently against them.

Empowering Vulnerable Adults

MPS Officers seek to empower competent Vulnerable Adults within the court system through the use of a range of Special Measures that can be used to facilitate the gathering and giving of evidence by vulnerable and intimidated witnesses.

Vulnerable witnesses are eligible for Special Measures support, to enable them to understand questions and be able to respond in a way that the court can understand. Some examples are:

- Communication aids – such as sign or symbol boards, which may help someone with understanding and answering questions. Communication aids can be used in conjunction with an Intermediary.
- Communication through an Intermediary – a specialist in assessing a person's communication needs and facilitating their communication, they may enable a witness to understand questions being put to them and to give answers that can be understood.

National Probation Service

Stuart Webber

Head of City of London, Hackney and Tower Hamlets



1. What has your agency undertaken to meet the SAB Principles?

All our learning will be shared learning

Safeguarding Adults is included in the NPS London Business Plan for 2015-16. There are a number of policy documents and processes, including some in development, which reflect the organisations commitment to safeguarding adults. These include: a NPS National Partnerships Framework for Safeguarding Adults Board, June 2015. Probation Instruction (PI)11/2015 Adult Social Care and PI 2/14 – Safeguarding of children and vulnerable adults.

NPS London has adopted the new London Multi-Agency Adult Safeguarding Policy & Procedures. In terms of applying the Procedures locally, staff will know the contact details in the Local Authority for feedback on referrals. Indicative timescales have been communicated regarding concerns, enquiries, safeguarding plan and review, and closing the enquiry. We are aware of the expected responses timeframe given in the procedures.

We will understand the complexity of local safeguarding needs

NPS makes referrals to the Safeguarding and Mental Capacity Team in Hackney when Probation officers consider offenders under their supervision, or adults linked to them, may fall under the remit of the Care Act. These referrals are not always necessarily deemed to meet the specific criteria. A recent MAPPA level 3 case being managed by NPS between two boroughs (within the LDU Cluster) required the involvement of the Safeguarding and Mental Capacity Lead. As a result of NPS's request for the attendance of this professional a referral to a neighbouring borough's Community Mental Health Team was facilitated via the offender's GP for an assessment for Asperger's/ Autism to ease access to support services and assessment resettlement plans.

Like MARAC, some of the actual or potential perpetrators of abuse and neglect may be subject to Multi-Agency Public Protection Arrangements (MAPPA). These are arrangements to manage the risk posed by serious sexual or violent offenders, including those who may also be the subject of a MARAC or an abuser within safeguarding processes. Practitioners and managers involved in safeguarding adults cases in NPS are expected to be familiar with the existing MAPPA strategy as found on our intranet NPS sites.

Providing meaningful statistics in respect of adult safeguarding is being reviewed as part of the nDelius Offender contacts database used by the NPS. Some contacts are being tested, such as contact details, registrations and flags. Moving forward, in the 2016-2017 year I will be discussing the provision of data with the NPS London Performance & Quality Team to see

if we can provide contacts specifically linked to Safeguarding Adults in the local authority areas where we work. Once we have meaningful data we will be holding thematic case audits focusing on Safeguarding Adult cases and will specifically review referrals during the latter half of 2016.

The skill base of our staff will be continuously improving

Safeguarding Adults is included in the NPS London Business Plan for 2016-17. There is a network of Senior Probation Officer and safeguarding adult practitioner Single Points of Contact (SPOCs) within each cluster or business area. There are also quarterly meetings for this group to discuss best practice and developments. There are a number of policy documents and processes, and some in development, which reflect the organisation's commitment to safeguarding adults and staff development. These include:

- *NPS National Partnerships Framework for Safeguarding Adults Boards* (June 2015).
- *Probation Instruction (PI)11/2015 Adult Social Care and PI2/14 – Safeguarding of children and vulnerable adults.*
- *Safeguarding Adults: a quick guide* – this has been issued to all staff, which reminds them of their responsibilities regarding safeguarding adults.
- *Safeguarding Adults at Risk Offenders in the Community with Care and Support Needs NPS Practice guidance* (Jan 2016) – this encourages staff to Think Safeguarding Adults at all stages of involvement with an offender. Safeguarding Adults from PSR stage at Court through to community supervision, APs, Prisons. Links between Safeguarding Adults and domestic abuse, extremism, hate crime.

Additionally, NPS London has produced a guide for probation staff working with suicide and Intentional Self-Injury. It gives guidance for frontline probation staff on effective ways of working with individuals who are suicidal or intentionally injuring themselves.

We will promote a fair and open culture

There is a nominated lead for Safeguarding Adults in the NPS London. A strong commitment to engaging in issues of abuse and neglect. This includes having senior managers' as portfolio leads across a range of public protection areas – safeguarding children, adults, domestic abuse, Serious Group Offending (Gangs), Central Extremism Unit. Senior managers are involved in a number of multi-agency forums regarding public protection, including MAPPA, MARAC, LSCB, SABs, YOS, CSPs etc. Additionally, Carina Heckroodt, Head of the Serious Crimes Advisory Unit is the London NPS lead on modern slavery.

The NPS's organisational culture supports reflective practice, case auditing, ensuring that lessons are learnt and that best practice shared internally and externally. Findings from Serious Further Offences, MAPPA, Safeguarding Adults Reviews and Serious Case Reviews are shared internally and where appropriate with external partners.

2. What difference has your agency made to improve the safeguarding of adults and promote their welfare?

The National Probation Service (NPS) is committed to reducing re-offending, preventing victims and protecting the public. The NPS engages in partnership working to safeguard adults with the aim of preventing abuse and harm to adults and preventing victims. The NPS has acted to safeguard adults by engaging in several forms of partnership working including:

- **Operational:** Making a referral to the local authority where NPS staff have concerns that an adult is experiencing or is at risk of experiencing abuse or neglect, including financial abuse, and is unable to protect oneself from that abuse or neglect.
- **Strategic:** Attending and engaging in local Safeguarding Adults Boards (SABs) and relevant sub-groups of the SAB. Through attendance, take advantage of training opportunities and share lessons learnt from Safeguarding Adult Reviews and other serious case reviews.

National training has been developed for staff. There is an e-learning module for all staff and in February 2016 a one-day face-to-face training course for staff who work directly with offenders which was rolled out. The training makes links to Prevent, safeguarding children, domestic violence and equality and diversity issues.

3. How does your agency evaluate its effectiveness and what evidence do you have?

NPS currently undertakes monthly case audits which involve all grades of operational staff reviewing specifically picked cases for auditing. Each audit deals with a number of specific Her Majesty's Inspectorate of Probation areas of review and incorporates assessments of staff adhering to safeguarding practices. It is desirable, as noted, that Safeguarding Adult data will assist the Hackney Head of Service to identify specific cases to review over 2016-2017 to specifically target practice in relation to offenders who may meet the relevant criteria for referral, and to follow the pathway and interventions being applied.

4. How has your agency challenged itself and others to improve safeguarding arrangements? What were the risks and impact of your challenge?

Safeguarding Adults at Risk NPS Policy Statement (Jan 2016)

Senior Manager lead within each Division. Promoting the duty to co-operate as a relevant partner under section 6 of the Care Act 2014. Making sure all staff are aware of their responsibilities. How to raise concerns? Practice Guidance is disseminated

EQUIP – a tool to quick reference policies and procedures – process maps.

Middle managers/senior probation officers are challenged to ensure that staff are aware of their role and responsibilities in relation to adult safeguarding and are familiar with local policy & procedures, including how to make appropriate referrals where necessary. They are aware of and review adult safeguarding cases being managed by their teams.

Our Safeguarding Adults at Risk Offenders in the Community with Care and Support Needs NPS Practice guidance (January 2016)

encourages staff are to Think Safeguarding Adults at all stages of involvement with an offender - from Pre-Sentence Report stage at Court through to community supervision, Approved Premises, and Prisons.

London Ambulance Service NHS Trust

Alan Taylor

Head of Safeguarding

The London Ambulance Service NHS Trust (LAS) has a duty to ensure the safeguarding of vulnerable persons remains a focal point within the organization.



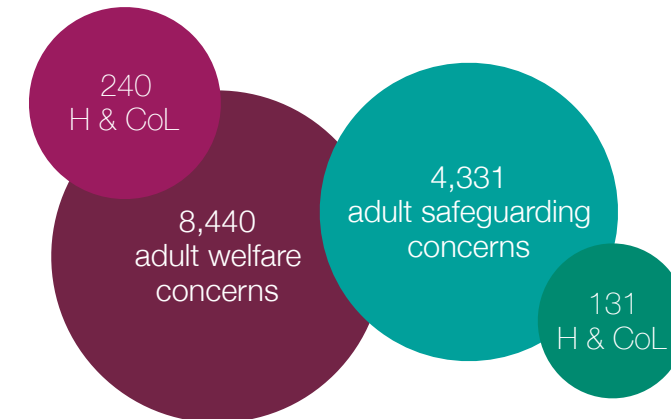
This report provides evidence of the LAS commitment to effective safeguarding measures during 2015/16. A full report along with assurance documents can be found on the Trusts website.

To address safeguarding our responsibilities we have:

- a safe recruitment process that includes the vetting and barring scheme and procedure with reference to the Independent Safeguarding Authority
- processes for dealing with allegations against staff with clear links to police and local authority designated officers
- a named executive director with responsibility for safeguarding
- heads of safeguarding for adults and children who are also the named professionals
- a safeguarding officer who is first point of contact for local safeguarding boards and local authorities
- internal and external reporting mechanisms to capture safeguarding issues
- a head of adult safeguarding acting as the LAS lead on Modern Slavery

The LAS is committed to ensuring that information is shared to prevent and reduce the risk of harm to adults at risk and has adopted the new London Multi-Agency Adult Safeguarding Policy & Procedures.

During the year 2015/16, the LAS raised 8,440 adult welfare concerns and 4,331 adult safeguarding referrals and to local authorities.



Across Hackney and the City of London there were 240 adult welfare concerns 131 adult safeguarding concerns referred.

The LAS is also committed to ensuring that all staff are compliant with safeguarding training requirements. This includes directly employed staff, voluntary responders and private providers who we contract to work on our behalf. Training includes safeguarding awareness, Prevent and Modern Slavery.

Locally, the LAS has supported the work of the CHSAB by contributing to Board and sub-group meetings and the CHSAB Development half-day, as well as supporting a Safeguarding Adults Review as both a cooperative partner and a Review panel representative.

Appendix 1: CHSAB partner attendance

Partner	Exec Group April 2015	Exec Group June 2015	CHSAB June 2015	Exec Group Sept 2015	CHSAB Sept 2015	Exec Group Dec 2015	Dev. 1/2 Day Feb 2016	Exec Group Feb 2016	CHSAB March 2016
Chair	P	P	P	P	P	P	P	P	P
City of London	P	N	P	P	P	P	P	P	P
City of London Healthwatch							P		P
City of London Police	N	N	N	N	N	P	A	N	P
ELFT	N	N	N	P	P	P	P	P	A
Hackney Healthwatch			A		A		P		P
HCVS			P		P		P	P	P
HUHFT	A	N	N	P	P	P	P	P	P
Ambulance Ser.							A		P
LB of Hackney	P	P	P	P	P	P	P	P	P
London/City of London Fire Bri.			P		A		A		P
Met. Police	P	P	P	P	P	A	A	N	P
Nat. Probation Service			P		A		N		P
City and Hackney CCG	P	P	P	A	P	P	P	P	P
Older People's Ref. Group			P		P		P		A
Public Health	A	A	A	P	P	P	P	P	P
Barts Health			P		P		A		P

Key

P = Present
 A = Apologies no substitute
 S – Substituted
 N = No apology or substitute recorded

* The London Ambulance Service started attending from February 2016 onwards

* City of London Healthwatch started attending from March 2016 onwards

Glossary

Abbreviation	Meaning	Abbreviation	Meaning
AAR	Adult at Risk	IMR	Individual Management Review
ACN	Adult Coming to Notice (used by Police Services)	IPR	Individual Practice Review
AD	Assistant Director	LAS	London Ambulance Service
ASC	Adult Social Care	LBH	London Borough of Hackney
CHSAB	City & Hackney Safeguarding Adults Board	LFB	London Fire Brigade
CoL	City of London	MARAC	Multi-Agency Risk Assessment Conference
CoLASC	City of London Adult Social Care	MAST	Multi-Agency Safeguarding Team (in City of London)
CoLP	City of London Police	MCA	Mental Capacity Act 2005
CPS	Crown Prosecution Service	MHA	Mental Health Act 1983
CQC	Care Quality Commission	MPS	Metropolitan Police Service
CVS	Council for Voluntary Services	MOSAIC	A case management system used by some local authorities
DASM	Designated Adult Safeguarding Manager	MSP	Making Safeguarding Personal
DCCS	Department of Community & Children's Services (in City of London)	s.42	Section 42 of the Care Act 2014
DCI	Detective Chief Inspector	SAB	Safeguarding Adults Board
DoL	Deprivation of Liberty	SAM	Safeguarding Adults Manager
DoLS	Deprivation of Liberty Safeguards	SAR	Safeguarding Adults Review
ECVCU	Economic Crime Victims Care Unit (used by City of London Police)	SAT	Safeguarding Adults Team (in Hackney)
EOC	Emergency Operations Control (in the London Ambulance Service)	SCIE	Social Care Institute of Excellence
ESCR	Electronic Social Care Record (in the City of London)	VAF	Vulnerability Assessment Framework (used by the Metropolitan Police Service)
HASC	Hackney Adult Social Care	VCS	Voluntary & Community Sector

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