Hillingdon Safer Adults Partnership Board Annual report 2011 - 12

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INTRODUCTION

This report covers the work of the Safer Adults Partnership Board (SAPB) during 2011-12. It highlights the main achievements in safeguarding Hillingdon's vulnerable adults, and identifies the priority areas for improvement for the following year and beyond.

This work relies on strong commitment and collaboration across services, and this is evident though the work of the Board, and from the contribution that each agency has made to this report. From these contributions we can see the efforts that are being made in Hillingdon to keep adults safe.

Hillingdon has dedicated safeguarding adults teams in social care and in the Police, which makes us well placed to respond effectively to concerns raised.

This year has seen a clear increase in awareness of the issues, evidenced from the increased number of relevant referrals to the safeguarding team. We have developed and embedded our local procedures based on the pan London procedures and collaboration across London continues to improve our ability to pick up on relevant developments, and contribute to the large amount of cross London work that continues apace.

Part way through the year we joined with the Local Safeguarding Children Board (LSCB) with meetings on the same day, and with the same chair, although each Board retains its separate identity. This collaboration is enabling us to work closely on some key issues, such as the planned Multi Agency Safeguarding Hub (MASH) and joint work across Children's and Adult Mental Health Services.

The evidence we have indicates that we are keeping adults as safe as we can within Hillingdon. However, there are some important challenges.

Local demographic data tells us that numbers of vulnerable adults in the Borough will rise.

National events, such as the Winterbourne Inquiry, remind us that we need to do more to ensure we are able to better monitor the care of vulnerable adults, particularly those who are in homes or hospitals.

We need to develop improved quality assurance mechanisms to assess the quality of our detection and interventions on the ground. The personalisation agenda, whilst extremely positive, means that we must help people assure themselves of the quality of care they are purchasing.

Government plans to place Safeguarding Adult Boards on a statutory footing are now clarified in the Care and Support Bill which outlines proposed role, membership and requirement to produce an annual report. Hillingdon SAPB is well positioned to meet the requirements of the new legislation and this annual report will be presented to the health and Wellbeing Board and the Council Cabinet

Hillingdon is the second largest of London's 32 boroughs. It has a population of approximately 266,100 at mid 2010 (269,011 by 2012) of which approximately a quarter are under 19.

Numbers aged over 65 are projected to increase to over 37,000 by 2015, and those over 85 are projected to increase to 5,500 –an increase of 11%. Although many of these will be living in the more affluent parts of the Borough, there are estimated to be upwards of 4700 frail elderly, many living in unsuitable housing and in areas of multiple deprivation. Numbers of adults with a learning disability and/or a mental illness are also projected to rise.

The most recent information indicates that 25% of women over 60 are non white. For men, measured at 65, it is 30%.

Hillingdon is a comparatively affluent borough (ranked 24th out of 32 London boroughs in the index of multiple deprivation, where 1 is the most deprived) but within that there is variation between north and south, with some areas in the south falling in the 20% most deprived nationally**.**

During 2011-12 2,816 adults received an assessment from Adult Social care. There were 2,300 reviews of existing service users and 5,861 people were in receipt of adult social care services. This represents a significant increase on activity from 2009/10.

Lynda Crellin

Independent Chairman

June 2012

1. WHAT WE HAVE DONE

What we planned to do – our key priorities

Priority 1 - Raising awareness of safeguarding adults amongst staff and engagement with the community

- Delivered a communications campaign to increase awareness of safeguarding adults through billboards, media articles and new posters focussing on the most prevalent areas of abuse, namely physical, neglect and financial.
- Refreshed public information on the website and developing new information on deprivation of liberty safeguards.
- Delivered an outreach programme of work to community groups in 1011-12 to raise awareness of safeguarding adults services and engage with key issues to inform developments in services

Priority 2 - Strengthening governance – safeguarding standards, processes and arrangements in partner organisations, evaluating cases / learning, build stronger links with other groups e.g. Domestic Violence Forum, Community Safety Forum and reviewing attendance at the Board.

- Worked across the London Boroughs to develop the London Multi-Agency Safeguarding Adults policy and procedures and introduced these into Hillingdon, enabling a consistency of practice across boundaries
- Partner agencies improved systems for monitoring alerts and referrals and improved activity reporting from IAS Protocol system, the main recording framework for safeguarding adults.
- THH was a pilot site to test the NHS London self assessment framework for vulnerable adults. The outcome was positive
- Audit of LB Hillingdon safeguarding adults' service and the processes and procedures received a very positive report.

Priority 3 - Strengthening skills / competencies in safeguarding adults

- Safeguarding training strategy and monitoring levels of take up by staff of partner training on safeguarding adults .
- Internal training programme delivered by each constituent agency

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Priority 4 - Analysis of outcomes / what difference we are making

- Analysis of acceptance of protection plans, for those who have been abused, showed good support for our intervention, where persons had capacity to express this.

<u>Priority 5</u> - Strengthening the prevention approach – e.g. advocacy, self-awareness

- Greater availability and use of advocacy service for safeguarding adults who are without representation and access to an independent mental capacity advocacy service for those lacking capacity to make decisions on their safety. New improved translation and interpreting service.

2. GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

The Safeguarding Adults Partnership Board is a multi-agency partnership comprising statutory, independent and charitable organisations with a stakeholder interest in safeguarding adults at risk. The Board aims to protect and promote individual human rights, independence and improved wellbeing, so that adults at risk stay safe and are at all times protected from abuse, neglect, discrimination, or poor treatment.

The role of the Board and its members is:

- To lead the strategic development of safeguarding adults work in the borough of Hillingdon.

- To agree resources for the delivery of the safeguarding strategic plan.

- To monitor and ensure the effectiveness of the sub-groups in delivering their work programmes and partner agencies in discharging their safeguarding responsibilities

- To ensure that arrangements across partnership agencies in Hillingdon are effective in providing a net of safety for vulnerable adults

- To act as champions for safeguarding issues across their own organisations, partners and the wider community, including effective arrangements within their own organisations

- To ensure best practice is consistently employed to improve outcomes for vulnerable adults.

Membership

Membership comprises all the main statutory agencies and voluntary groups who contribute to the safeguarding of vulnerable adults. A full list of members can be found at appendix 1. Overall attendance during 2011/12 was 65%, with Hillingdon Community Health, Hillingdon Hospital Foundation Trust, the local authority and Age UK Hillingdon showing 100% attendance; DASH and Hillingdon Carers showing 75%; Metropolitan Police and MIND showing 50% and CNWL and the London Fire Brigade showing 25% attendance. New attendees from Harefield and Brompton Trust, UKBA and London Probation were welcomed at the March 2012 Board meeting.

The Cabinet lead member for Adult Social services sits on the Board, as well as the Corporate Director, Social Services, Health and Housing

Our main membership gap is that of General Practitioners and of the Clinical Commissioning Group (CCG). GPs are critical in the context of vulnerable adults, as the professional most likely to be in contact with them, and in a position to pick up on concerns, whether at home or in residential care. This gap will be closed, following new Department of Health guidance issued to CCGs in September 2012 and current discussions on local representation for both children and adults' safeguarding boards.

Independent chairman

Since November 2011 the SAPB has been chaired by an independent chair, who also chairs the LSCB. Some local authorities are moving towards independent chairing, especially those who have returned to a combined children and adult social care system. In Mach 2012 the SAPB agreed a protocol that set out the roles and responsibilities of the chair

Relationship to agency boards

There are links across to the Safer Hillingdon Partnership and Healthier Communities for Older People. Safeguarding also links to the Multi Agency Public Protection Arrangements (MAPPA) and the Multi Agency Risk Assessment Conference (MARAC) We have tried in this annual report to better reflect the partnership work in Hillingdon, and have asked the agencies represented on the SAPB to make their own direct contributions to this report. We asked about governance and contributions to safeguarding, and these are included below. Actions planned within each agency are included in section 7.

Hillingdon Council

The Council is the lead agency for safeguarding adults**.** The Director of Social Care Health and Housing (statutory DASS sits on the Board and the annual report will be presented to Council's Policy and Overview Committee and to Cabinet.

Safeguarding adults at risk is a lead responsibility for Local Authorities. Government guidance in the form of the "No Secrets" document issued in 2000 set out the responsibilities Local Authorities have in developing and implementing multi agency policies and procedures to protect adults at risk. Hillingdon's local policy, based on the guidance, was first developed in 2001

and revised in 2005. In 2011 London Multi-Agency Safeguarding Adults at Risk polices and procedures were developed and implemented across the London boroughs, facilitated by the Social Care Institute for Excellence (SCIE). These were endorsed by LB Hillingdon's SAPB and implemented locally in September 2011. Practitioners' guidance, based on the policies and procedures, is to be launched in June 2012. LB Hillingdon has been heavily involved in the development of the procedures and guidance through our chairing of the London safeguarding adults' network, a self supporting network of local authority leads for safeguarding adults.

LB Hillingdon has a dedicated safeguarding adults' service that handles all allegations of abuse, working with adult services' teams and partner agencies. Each major partner has an appointed safeguarding lead manager or senior practitioner to link with LB Hillingdon on operational issues and to work jointly on investigations, where their expertise is needed. In addition, the safeguarding service works closely with LBH's contracts inspection team, and with the Care Quality Commission (CQC).

In line with all organisations, LB Hillingdon has been seeking to identify efficiencies in their structure and activity. In 2011, Adults' Social Care and Children's Services were combined under one Directorate. This prompted consideration of the work of the Local Safeguarding Children's Board (LSCB) and the SAPB, as there have been overlapping common themes, for example, safer recruitment of staff who work with adults at risk and children. Both Boards accepted that there was considerable scope for working more in collaboration whilst maintaining the distinctiveness of the adults and children's safeguarding agenda and maintaining two Boards.

The LSCB and SAPB are now chaired by one, independent chair, and the timing and frequency of Board meetings has been changed to ensure the Boards meet on the same day with an overlap period for joint agenda items. The first meetings under the new structure took place in November 2011. The terms of reference of both Boards were reviewed to ensure they are aligned whilst retaining their respective focus on adults or children. The new structure will achieve better use of staff and agency time and open up opportunities for further joint working in the sub-groups of the Boards. Membership of the children's Board has been reviewed, and membership of the adult's Board will be reviewed in the light of new statutory requirements anticipated in the near future.

Joint items already considered include domestic violence, and the development of whole family preventative services, including Multi Agency Safeguarding Hubs (MASH)

Voluntary Sector

Voluntary Sector agencies are critical to our work, and are well represented on the Board.

Age UK Hillingdon

Internal governance arrangements in respect of adult safeguarding

AUKH is committed to the protection of vulnerable adults. The organisation has developed and implemented a range of policies and procedures to provide its staff and volunteers with the confidence and knowledge to identify potential abuse and act on it appropriately: These include:

- Whistle blowing Policy
- Procedure For Obtaining Disclosure Information From The Criminal Records Bureau Under The Data Protection Act
- Protection of Vulnerable Adults Policy
- Gifts and Donations Policy
- Safer Recruitment Policy
- Confidentiality Policy (when confidentiality can be breached)

The policies are tested and reviewed regularly; they are included in the Staff Handbook, highlighted as part of the induction training of all staff and volunteers and reinforced through mandatory safeguarding training.

Safeguarding is a standing agenda item for staff and volunteer meetings.

Any trustees or senior managers involved in recruitment must have undergone Safer Recruitment training.

Your agency's contribution to improving safeguarding during 2011-12

During the year the organisation has worked in partnership with the Disability Association for Hillingdon to deliver a Safeguarding Advocacy service on behalf of the local authority supporting vulnerable adults through the safeguarding process.

Age UK Hillingdon and Hillingdon Carers has worked together to provide a support group for relatives of residents in care homes in Hillingdon (RRICHH). During the year the group has gained funding to recruit volunteers to be trained as advocates and placed in care homes in the borough.

The Ethnic Minority Access Project run by Age UK Hillingdon has facilitated meetings with older members of the Black and minority communities to raise awareness of abuse and has supported individual victims to report abuse.

Age UK Hillingdon has worked with the Council's Customer Engagement Team to enable housebound older people to have their say about services

through the Befriending Service. In addition, the contract monitoring unit manager is providing written guidance to Age UK Hillingdon's staff and volunteers who visit older people in their own homes or in care homes, on what standards of care should be in place so that they can identify potential shortcomings that could lead to abuse.

The organisation has produced the Hillingdon Handbook, a directory of services for older people which includes information on what abuse is and how to report it.

Age UK Hillingdon has good relationships, through both Advocacy and RRICHH, with the Inspection and Monitoring team, and has referred to them on occasion.

Age UK Hillingdon's Human Resources Manager has been an active member of the working group on HR.

DASH

DASH has adopted the London Borough of Hillingdon safeguarding adult's policy and also follows safer recruitment guidelines. The Chief Officer has undertaken safer recruitment training. All staff and volunteers are subject to enhanced CRB checks and full reference checks.
Our Side by Side project in conjunction with Age UK Hillingdon ensures that all people who are going through the safeguarding process have access to an independent advocate should they wish to have one. This means that they have someone who can accompany them to interviews etc and can help them to understand what is happening.
Staff and volunteers are encouraged to raise concerns firstly with the Chief Officer or directly with the safeguarding team if they feel it appropriate. As we visit many people in their own homes staff are made aware of what to look out for to keep people safe.
Our intention for the coming year is to ensure all staff and volunteers are kept informed about safeguarding and access refresher training. We will also work closely with all the other agencies.

HILLINGDON CARERS

Hillingdon Carers has continued to place a high emphasis on Safeguarding during 2011-12.

Arrangements that have been reviewed and continued are:

Hillingdon Carers Safeguarding Vulnerable Adults Policy (mirroring multi-agency policy and procedures locally).

Specific inclusion of Safeguarding issues in every staff supervision (including administrative staff who answer the telephone to our clients).

Regular training for all staff/volunteers who have contact with clients.

Continued use of Safer Recruitment practices and enhanced Criminal Record Checks for relevant new and existing staff and volunteers.

Safeguarding prompts on all assessment documentation/checklists for casework with clients

Initiatives in 2011-2012 were:

Supported the London Borough of Hillingdon Safeguarding Vulnerable Adults Publicity Campaign by displaying the posters (in the correct sequence) within our Advice Centre in Uxbridge High Street.

Created special display over Christmas 2011 to alert passers by to Safeguarding – we had fantastic feedback on this (you could read it from a passing bus) and it was certainly a very direct message (see attached photograph).

Placed permanent prompt on home page of Hillingdon Carers website.

Organised in-house group training for staff so more challenging issues could be discussed as a team.

Organised 2 Safeguarding Awareness sessions for carers at drop-in Carers Cafes as part of our 'Bite sized' training for carers programme which enable carers to gain information in short sessions and to which they can bring the person they support. The trainer in this case was provided by Hillingdon Community Health.

Health Agencies

Health services remain in a state of change, with the move to Care Commissioning Groups led by GPs due from April 2013.

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The Hillingdon Hospitals NHS Foundation Trust

Internal governance arrangements in respect of adult safeguarding

The Hillingdon Hospitals Foundation Trust (THHFT) was one of the early implementer sites for the Self Assessment Assurance Framework (SAAF).This is a tool devised by NHS London (NHSL) for organisations to

assess themselves in terms of Safeguarding assurance. The SAAF is now cross-referenced with CQC Outcome 7 (regulation 11): 'Safeguarding people who use services from abuse'. Both these tools give the Trust assurance in terms of safeguarding, and is an agenda item twice yearly on the SASG (now the Safeguarding Committee) to review .Clinical cases/issues were also on the agenda for discussion at the SASG. There is a strong working relationship with both Clinical and Information Governance in relation to Safeguarding. A paper is then submitted after each meeting to the Clinical Quality Steering Committee (CQSC).

THHFH has been referenced in March 2012 in the NHSL Pan- London Thematic review of the SAAF as examples of good practice, including strategy and involvement and listening to and acting on user views. A presentation was delivered by the Head of Safeguarding at the Outer NWL NHSL meeting on the implementation of the SAAF towards the end of 2011.

The Good Practice Guidelines for patients with a Learning Disability has been revised. In addition the Trust intranet pages for Vulnerable Adults, Learning Disabilities, MCA and DoLS have been updated.

The Head of Safeguarding is now the Trust lead for the PREVENT counter terrorism Strategy. An additional SAAF for PREVENT has been completed for the Trust .There is also regular attendance at the Hillingdon PREVENT Partnership Group.

The Hillingdon Hospitals Foundation Trust's contribution to improving safeguarding during 2011-2012

Level 1 mandatory training in Vulnerable Adults is delivered monthly. In addition, monthly training is delivered to all new starters to the Trust. Bespoke sessions are also arranged. Specific presentations for MCA and DoLS have also been delivered by the Medical Safeguarding Lead, which included a presentation at the surgical audit meeting, which includes Consultants.

A domestic violence session has been delivered to Trust staff by Hestia and a further session has been planned for later in 2012.

The Trust has revised a process flow chart for staff on what to do if a patient presents with Domestic Violence, which also includes what to do if the person has a child. There is also a flow chart devised, in partnership with police, for the process to follow if an in-patient is to be interviewed as part of a safeguarding investigation.

The Head of Safeguarding was part of a working group devising an e-learning tool at NHS London called:' providing high quality care for vulnerable patients'. This includes the safeguarding of learning disability and dementia patients, accessible via the e-learning repository.

In September 2011, there was a Joint THHFT and HCH Safeguarding Event, focussing on PREVENT Domestic Violence and MCA / DoLS, with positive feedback. This is an example of the close working relationship with the Safeguarding Adults Team at HCH.

The Trust hosted the second 'Benchmark of Best Practice' workshop in March 2012,
The event focused primarily on the experiences of patients and carers accessing services at the Trust. Many positive experiences were discussed as well as suggested areas for improvement. Sessions were delivered by two groups of service users with learning disabilities, along with their support workers, with excellent feedback from attendees. A particular session held by a carer with her daughter who has a profound learning disability was significantly powerful and thought-provoking, providing valuable learning for those present. The event was attended by NHSL and MENCAP.

The Patient Passport, primarily people /patients with a Learning Disability, is now a joint document with THHFT,HCH and CNWL.

There is a Trust 'Safeguarding Matters' newsletter, which is sent to all staff on a quarterly basis, covering both adults and children.

A DoLS audit in 2011 was carried out. The two aims of the audit were to determine the number of patients with DoLS issues and discover if they had been referred for a DoLS assessment. A total of 57 medical patients were audited of which two were found to have possible DoLS concerns. The audit demonstrated that staff needed a greater awareness and understanding, which currently are being actioned by further training and support.

In February 2012, there was re-audit of staff knowledge and awareness of MCA and DoLS. The results indicated that more awareness sessions were needed for staff specifically on MCA and DoLS and to reiterate who to contact for advice and support. There was also an audit on Learning Disability awareness and how the Trust staff look after these patients in hospital. The results were positive, and that staff knew who to contact if there were concerns. There needs however, to be increased awareness and use of the patient passport

Central and North West London Health (CNWL)

CNWL Governance Arrangements
Safeguarding adults work in the Trust has continued to expand. A number of cases have proved to be particularly complex and distressing for those involved. Awareness of the issues around adults at risk continues to rise across all service lines.

Safeguarding Adults - The Process and Pathway in each Borough

CNWL has a Safeguarding Adults Steering Group, with membership made up from leads within the trust and Local Authority partners. This group reports to the quarterly Adult safeguarding Group. The Trust Safeguarding Leads are setting up meetings between each local authority and the service lines that

serve that borough. The aim of these meetings is to ensure that each service line understands its roles and responsibilities in that borough and for each service line lead to meet the borough local authority lead. We now have dates for 7 of the 11 Local Authorities the Trust works in partnership with to deliver health and social care services. We have completed meetings for the Boroughs of Westminster and Hillingdon and hope to have completed all meetings by early autumn 2012. The expectation on the Trust from local authority partners varies depending on the structure the local authority employs and whether or not the Trust has a S75 partnership agreement with that borough.

A CNWL Adult Safeguarding Workshop was held on 23rd November 2011 with an invitation to all 12 Service Lines and the 10 Local Authorities who work in partnership with the Trust on this agenda. The outcome will now begin to inform our current work plan in a number of key areas.

CNWL Safeguarding Adult Guidance

A revised adult safeguarding guidance document has been produced in draft and disseminated to the Trust Adult Safeguarding Steering Group. This draft was achieved through close collaboration with Service Line Leads and Local Authority partners to ensure an effective and consistent response to allegations of abuse. Its aim is to assist staff in identifying potential or actual abuse and a simplified flowchart with pathway and process information for each borough will be included. This is line with recently produced Pan-London Procedures and Department of Health Clinical Governance guidance. A copy of this guidance document will be provided to the next Quarterly Quality Review committee.

Hillingdon Community Health

(i) **Internal governance arrangements in respect of adult safeguarding**

Hillingdon Community Health (HCH) joined with CNWL in February 2011. As the statutory organisation, CNWL has overall governance responsibility for all adult safeguarding activities/issues occurring across the organisation, including HCH. The Director of Operations and Partnership is the Board level lead for Safeguarding across the Trust. However, this is strengthened through the maintenance of local governance arrangements within HCH which feed into wider Trust structures.

Specifically, there is an overarching CNWL Safeguarding Committee which meets quarterly and is attended by HCH's Managing Director and the HCH Safeguarding Adult and Children's Leads.

HCH's Managing Director chairs the local HCH Safeguarding Group, at which standards, policies, audits and lessons learnt are discussed and presented. Appropriate people from other organisations attend as well as

all HCH safeguarding leads and practitioners and Heads of Adults and Children's services.

HCH has its own Safeguarding Adult's Policy which is reviewed and updated every two years.

NHS London's Self-Assessment Assurance Framework has been completed, and is regularly reviewed and updated to identify any gaps in service.

A quarterly safeguarding governance report is prepared and presented to HCH's Senior Management Committee and to the CNWL Safeguarding Committee.

HCH's contribution to improving safeguarding during 2011-2012

HCH's Safeguarding leads raise awareness of safeguarding adults issues amongst staff by attending team meetings, by going to individual teams and discussing safeguarding and MCA case studies. The safeguarding adults team also go to out to community services including sheltered housing coffee mornings, older people's luncheon clubs, clubs and societies, groups at libraries and some religious groups to give talks to ensure that the public know what safeguarding is and who to contact. The team man a table with literature regarding safeguarding adults in Uxbridge Pavilions on Carers days and Older Peoples days. They have an afternoon once a month when they visit Learning Disability and Older Peoples Residential Homes, Learning Disability and Older Peoples Day centres. They have gone to every GP's surgery in Hillingdon to give talks for the staff at their practice meetings. They have attended the GP and practice managers meetings in Hillingdon's 3 localities and given talks. They have also given a talk to raise awareness at the GP master class. They take literature to flu clinics at some GP surgeries and discuss abuse and rogue traders whilst the patients are queuing for their injections. They have given talks for community dentists and opticians. They have also given talks to staff at Domiciliary Care Agencies.

They deliver all mandatory training for all Hillingdon Community Health staff; they offer training for GP's and give teaching sessions for student nurses. The SGA Team have also been involved with joint SGA events with Hillingdon Hospital.

HCH's safeguarding adults team give all safeguarding adults mandatory training, they offer support to staff who have referred patients to LBH's safeguarding adults team. The safeguarding adults team receive their training from LBH, but also attend study days and conferences. The safeguarding adults lead has recently completed The Leadership in Safeguarding Adults Course which was sponsored by NHS London. They ensure they participate in regular peer meetings with other NHS safeguarding leads across London.

Following the results of the SAPB staff survey in 2010-11, HCH SGA team did a follow up audit of phone queries and cases referred to SGA by HCH staff in the months of April, May and June 2011. This showed that the HCH's SGA had significantly more queries and cases referred in 2011 as at the same time in 2010. Other internal audits that were led by HCH's SGA team were a Dignity Audit, which showed that patients seen by HCH clinicians for Adult services felt that they were receiving a service that considered their dignity. The team also led on a staff audit regarding their knowledge around people with Learning Disabilities, this audit showed that raising awareness of reasonable adjustments needed to be put in place for staff, these awareness sessions are currently running.

One of HCH's SGA Team's main strength is their partnership working. They work closely with Hillingdon Hospital's SGA Lead, and get involved with meetings and joint events. They have good links with the voluntary. They have a role in Safeguarding investigations and take this role seriously, ensuring that they know individually each member of LBH's SGA Team. They work with LBH's Social Care Inspection Team and often accompany them on visits to nursing homes, and give comments and feedback on the health aspect of the care.

Metropolitan Police

Safeguarding Adults at Risk Policy

Internal Governance.

This policy introduces an enhanced and prioritised procedure for the investigation of Safeguarding Adults at Risk cases to create a framework for all staff to provide an effective, professional and corporate level of service. . The MPS is keen to ensure that not only does it maintain its commitment to London's diverse population with regard to the investigation of Safeguarding Adults at Risk incidents but also that the organisation builds on the work developed since the establishment of Community Safety Units (C.S.U.s).

Hillingdon Borough.

Has developed an enhancement of this corporate policy within its Community Safety Unit based at West Drayton Police Station. Hillingdon Borough maintains and supports a dedicated Safeguarding Adults at Risk Investigation Team . No other Borough within the MPS has this capability.

It is self evident in the annual statistics regarding the investigation of Criminal Offences perpetrated against Vulnerable adults

FYTD-Hillingdon Borough were responsible for recording

19% of all Disability /Hate Crime incidents

23% of all Disability/HateCrime offences

67%of all Disability/Hatecrime Detections

69% of Offences investigated were Detected.

London Fire Brigade

Internal governance arrangements in respect of adult safeguarding

The LFB has a Safeguarding Adults at Risk Policy which defines neglect and the scope of abuse. It also details the reporting procedure all staff must complete in order to raise an allegation with the relevant Social Services Dept. (SSD). Whilst any member of staff may report neglect or abuse the decision to forward the allegation to a SSD is taken at Deputy Assistant Commissioner (DAC) level. The DAC's decision is based on a brigade guidance note (which details key factors that must be considered) and, when considered necessary, consultation with the SSD. A record of all referrals is maintained on a secure database only able to be accessed by a limited number of people.

· Your agency's contribution to improving safeguarding during 2011-12:

During 2011 – 12 fire crews and senior officers received LFB training on the Safeguarding Adults at risk policy issued during the course of that year.

The LFB was represented on the Hillingdon's Safeguarding Adults Partnership

Advice on home fire safety was provided when appropriate in relation to specific cases

At least 2 referrals were made by the LFB to the Hillingdon SSD (data not available at time of writing)

Financial arrangements

The Coalition Government has indicated in the draft health and social care Bill that they intend to put Adult safeguarding Boards on a statutory footing. Depending on the statutory scope of the SAPB's work this may have financial implications for LB Hillingdon and partners in needing to support the work of a new Board. Currently the commitment of partner agencies is through officer time and some designated posts. However, LB Hillingdon's adults and children's Boards working with each other will enable efficient use of existing resources.

Sub groups

Most activities relating to the SAPB business plan have been led by the Service Manager. The only significant operating sub group has been Human resources (HR) which is a joint group with the LSCB. At the March SAPB membership was sought for the following sub groups and these will become operational in 2012

Policy and performance

Learning and Development

Serious case Review sub group

Financial Exploitation (short life group)

Terms of reference for sub groups are included as an appendix to this report.

3. LEARNING FROM CASE REVIEWS

Serious Case Reviews (SCRs)

LB Hillingdon had no serious case reviews in 2011-12. However, research was carried out across London reviewing 18 SCRs involving 15 councils, in the last 2 years. The researcher obtained SCR overview reports, action plans, and information about monitoring arrangements.

A major part of the learning related to safeguarding procedures, with main findings being:

- Failure to invoke procedures
- Not recognising specific triggers, particularly neglect
- Non adherence to procedures – delay, non attendance
- Lack of management oversight
- Not sharing or passing on critical information
- Lack of sufficient engagement with service users and their families

The main more strategic issues were:

- The need for robust commissioning and contract compliance that is integrated with assessment and care management processes
- Recognition of where commissioned care are not meeting needs and responding to changed circumstances and high risk situations
- The need to improve staff competencies, particularly in key provider service areas –first aid, tissue viability, emergency response, dealing with complex needs/challenging behaviour, awareness of specific health conditions.

Another study was undertaken nationally by the Social are Workforce research Unit in association with Kings College. Many of the key issues reflect the London learning, and additional areas reflected the need to ensure that whistle blowing policies and procedures are working correctly and that the effectiveness of advocacy and other representation is improved. A thematic analysis around dementia raised concerns about staff competence and recording practices in some care settings. Also the role of GPs in monitoring service quality.

Both studies identified a lack of consistency in criteria for SCRs, and a need to make sure that lessons were learned and actions implemented swiftly. In addition, the importance of ensuring that there is clarity when a management/staffing issue becomes one of safeguarding. In Hillingdon there is a clear understanding of the primacy of the safeguarding process in dealing with allegations that may ultimately come within agencies' disciplinary processes. Action is taken first to ensure the protection of adults potentially at risk from the alleged actions of staff, with internal procedures following.

Other cases.

In 2011 Hillingdon was the subject of a High Court action relating to a service user, SN, and the application of deprivation of liberty safeguards. Monitoring completion of the resulting action plan is being undertaken by the Senior Management Team of LB Hillingdon. Actions completed included:

- Additional training for relevant staff on the legislation
- The appointment of a senior practitioner to strengthen the service.
- Revising procedures to ensure a more human rights' approach to practice.
- Revised guidance to best interests assessors (BIAs).
- Improving information available to the public and to representatives on their rights.

A management review in respect of another case was carried out in spring 2012. The review involved a family with children where a parent had a mental illness, and was a joint review by Hillingdon Council and CNWL. The following key learning points were identified:

- The need to refresh and reactivate the existing inter-agency protocol between Mental Heath services and Children & Families Service, particularly the need for professionals to meet and develop a fully multi agency assessment of need, and an understanding of language used in case planning across the two agencies
- The need to ensure that staff in both services are able to take account of the impact of actions on children and adults in a family.
- The need to improve management oversight in order to ensure that the two actions above could be implemented

Safeguarding Adults Team has worked to improve links with the Central NW Mental Health Foundation Trust and each mental health unit has a designated safeguarding lead. Workshops have been set up with mental health managers

and front line workers to focus on safeguarding issues and how our services work with each other using the London multi agency safeguarding procedures.

4. WORKFORCE

During 2011-12 the Safeguarding Adult service in LB Hillingdon was restructured to shift the balance of the team to more qualified staff within the existing staffing resources to ensure that the growing complexity of safeguarding work could be handled. There are currently 12 qualified social workers (10. 5 full time equivalents) in the LBH service with close management oversight, signing off each stage of the safeguarding process. Partner agencies have also strengthened their response to safeguarding adults through safeguarding lead posts, either as a specific responsibility or as a part of their existing responsibilities. This has helped to create a network of staff across Hillingdon to lead in this area of work.

There is an e-learning module on safeguarding adults awareness available to all relevant agencies. 330 staff have registered to access this learning module. 88 have completed and 35 are in the process of completion.

Whilst individual partner agency training has proved effective in ensuring staff awareness, multi-agency training opportunities, similar to the programme the children's Board have developed, is a priority to take forward for the next year. This will form part of the training sub-group's work programme.

75 front line LBH reablement workers who provide focussed rehabilitation to promote a person's independence in their own home have received safeguarding training

5. HOW WE ARE DOING: effectiveness of local safeguarding

How the SAPB monitors local safeguarding arrangements

The SAPB uses a variety of information to assess the effectiveness of local safeguarding arrangements. These include annual returns, inspection reports, and quality audits. During 2012-13 we will have improved performance information based on the annual safeguarding adult returns submitted to the Department of Health. The focus will include more outcome data to ensure intervention is effective.

Effectiveness of local arrangements to safeguard adults

Performance information

The full annual returns can be found as an appendix to this report. Many of these are consistent with the local population demographics and with other comparator authorities

One key area of improvement has been an increase in the proportion of alerts that become referrals

Safeguarding Adults Contacts: Alerts 775

Referrals 472

Total = 1,247

(Alerts are safeguarding concerns that are taken by the safeguarding team, screened, and then found not to trigger safeguarding procedures but require a care management solution e.g. review of care arrangements. However, an accumulation of alerts will often trigger safeguarding procedures. Referrals are safeguarding concerns that trigger the safeguarding procedures at the point of screening.)

The corresponding figures for 2010-11 were 941 alerts, and 401 referrals. This indicates that referrers are becoming much more aware of what constitutes a safeguarding concern. Hillingdon had a much higher level of alerts than comparator authorities, and these figures indicates that relevant issues have been addressed

Ethnicity of Alerts/ Referrals:	**British white and all other white 80%** **Non-white 20%**
Main categories of alleged abuse:	**Physical 28%** **Emotional / psychological 19%** **Financial 23%** **Neglect 22%**
Main location of abuse:	**Own home 61%**
Main alleged perpetrator:	**Partner or family member 38%**

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LB Hillingdon had a higher percentage, than the comparator group, of safeguarding contacts where the person was previously known to social services and a slightly lower percentage where the referrer was a self, friends or family contact. Together this may indicate the service needs to reach out more into the community. However, it could be argued that mainstream services are being effective in reaching those most in need in the community.

When levels of satisfaction about safeguarding intervention were measured, 55% of service users said they were satisfied. 30% lacked capacity to respond and we hope to be able to use information from carers and advocates to get a better assessment from this group in the future.

The LB Hillingdon safeguarding adults at risk service was subject to an audit of their work by the internal audit and compliance team. This inspection, completed in early 2011, focused on the robustness of policies and procedures, whether they are embedded in practice; performance and the management oversight of work. The service received a very favourable report. One outstanding recommendation, relating to improving the risk assessment profile, required a change in the safeguarding module within IAS Protocol.

This has finally been achieved and will be tested before being inserted into the “live” network.

Mental Capacity Act and Deprivation of Liberty

There is currently a joint Supervisory Body for LB Hillingdon and Hillingdon Primary Care Trust. With the phasing out of PCT structures, responsibility will revert to the Local Authority as the sole Supervisory Body. There are currently 7 Best Interests Assessors and the work of the Supervisory Body is overseen by the Service Manager for safeguarding adults, with support from a Senior Practitioner and Administrative Officer.

In 2011/12 there were a total of 6 requests for a standard authorisation and 6 urgent authorisations received. Of the standard authorisations, 2 were granted and 2 were not granted. 2 requests for a standard authorisation were not proceeded with on the grounds they did not meet the criteria. In one instance an acute confusional state was quickly resolved, as expected, with consequent change to normal health care arrangements. In the second case, the person's wish to leave the care home related to anxiety about family financial matters occurring outside the home which were quickly resolved and the person was happy to remain in the care home and receive appropriate care.

Deprivation of liberty relates only to people in registered care homes or hospitals. In 2011/12 there were 2 requests for standard authorisations from hospital settings. None were authorised. For care homes there were 4 requests for standard authorisations of which 2 were granted and 2 not granted.

Care homes and hospitals, known as "managing authorities" under the legislation can give themselves an urgent deprivation of liberty authorisation of not more than 7 days, pending assessment for a standard authorisation. In 2011/12 there were 6 urgent authorisations, of which 2 then went on to receive a standard authorisation. Further work is being done with hospital safeguarding leads to ensure urgent authorisations are invoked appropriately.

Outcomes of audits and Inspections

The safeguarding adults at risk service works closely with their colleagues in the inspection team of LB Hillingdon. The role of this team is to monitor the service provision and quality of care of those providers contracted to the LB Hillingdon. The team undertakes reviews of services, including unannounced inspections, and ensures the provider is working to good standards of care and is contract compliant. Monthly reports on service providers are submitted to LB Hillingdon’s senior management team and contract monitoring meetings are held with the service providers themselves.

In 2011/12 the team made 115 visits to people in registered care home placed by LB Hillingdon. The outcome of visits and any recommendations arising are

recorded with subsequent tracking of individual care homes to ensure recommendations are actioned by them. Similarly, complaints about social care providers are tracked and followed up. In this way the team can build up a picture of how individual care providers are meeting the needs of those people who are in their care. The team are working on new ways to collate overall performance of social care providers contracted to LB Hillingdon.

The team are particularly important in monitoring required improvements for settings where there have been safeguarding concerns and in linking with colleagues in the Care Quality Commission (CQC) on the regulatory standards providers must comply with. An example of this joint work, both with CQC and our social services colleagues in Ealing, concerned a care home located in Ealing where LB Hillingdon had made a number of placements. The resulting improvement plan is being monitored, with Ealing leading on this particular case

.**Personalisation**

Personalisation is centred on putting the individual and their family in control of their care and support enabling them as far as is practicable to make their own choices and manage their care and support as they would wish to for themselves. A significant part of personalisation is the provision of personal budgets; funds which the individual and their family can manage and spend to provide for their care and support needs. Personal budgets are at the heart of transformation of adult social care. The aim is not only to provide funds via personal budgets but assistance to manage funds and working with providers and the voluntary sector to build alternative support services so that service users have more choice, opportunities and can be more innovative on how their needs can be met. There is a move away from traditional, social care providers to a broader range of provision, some of which may fall outside current regulated services, for example the employment of personal assistants and small voluntary groups to meet care needs. This has posed a challenge as to how the existing framework of safeguarding will ensure the safety and protection of vulnerable adults within this new context of greater choice, individual control and proportionate risk enablement. Currently just under 50% of Hillingdon's social care users are receiving self directed support (SDS) and this percentage continues to increase each month; by the end of March 2013 all eligible service users will be in receipt of a personal budget . This option is not, to date, applicable to health services. So far, the majority (90%) have opted for Hillingdon to manage their care arrangements, but numbers electing to have their personal budget paid direct to them so that they can manage their own support is increasing with the use of prepaid cards. Risk enablement is an integral part of the support planning process for these service users seeking to make their own support arrangements. Risk enablement guidelines and processes have been introduced and these have been covered as part of a wider self directed support training programme. As yet, this has not impacted on safeguarding adults at risk. The service will continue to monitor the situation and advise the SAPB accordingly. To date there is no indication of a disproportionate number of SDS referrals being made to the safeguarding team.

Feedback from staff

In May 2012 17 staff and managers from across agencies attended a half day workshop. It was an interactive day that focused on the SAPB priorities, and on messages from Serious case Reviews across London. The aim was to incorporate views of front line staff into SAPB planning.

Those attending supported the main priorities of the SAPB and identified the following areas for action:

- A need for more training and awareness across agencies, particularly in respect of mental capacity and deprivation of liberty
- Use of cases, case audits and case examples to inform and improve practice
- A need to improve partnership working and information exchange –with Police, CPS, care providers
- The need to be able to use inspection and monitoring of care providers to drive up standards.
- Better support services, particularly in respect of mental health and support for carers.

Some staff also identified trigger points when things could go wrong – particularly at point of movement -e.g discharge from hospital, change of placement.

Staff welcomed the opportunity to engage with the Board and wanted more interactive days and more communication from and to the SAPB

Overall effectiveness

The information we have gives reassurance that the multi agency system to safeguard adults in Hillingdon is working well. There is strong multi agency commitment through the SAPB and evidenced by the information provided in this report. Our performance figures are broadly in line with comparator authorities, and, where they are not, in the case of high numbers of alerts, action has been taken to address the issue. There was an increase in the number of appropriate referrals which does demonstrate an increased awareness in the key safeguarding issues.

The dedicated investigation team ensures that concerns can be responded to promptly and effectively and has been quoted as an example of good practice London wide.

The progress of work across London and nationwide is ensuring that agencies are working within a context of sound practice and guidance, thus ensuring greater consistency and higher standards of care.

A big issue for the SAPB in the next year is to improve our knowledge about the effectiveness of our work in terms of outcomes for users, and to ensure that opportunities for learning are taken and carried forward .

We also need to find ways of assuring ourselves of the quality of care of those vulnerable adults placed away from home, the Winterbourne events being a salutary reminder of what can go wrong.

6. NATIONAL AND LOCAL CONTEXT: implications for safeguarding

The statement of the 16th of May 2011 of Government policy on adult safeguarding by the DH made clear that the "No Secrets" statutory guidance would remain in place until at least 2013. The principles within the statement were building on this guidance, reflecting what had come out of the national consultation process. They made clear that the Government's role was to provide the vision and direction on safeguarding, ensuring the legal framework, including powers and duties, is clear and proportionate, whilst allowing local flexibility. Safeguarding is seen as everyone's business encouraging local autonomy and leadership in moving to a less risk adverse way of working, focusing more on outcomes instead of compliance.

The Government set out six principles by which local safeguarding arrangements should be judged.

- Empowerment – presumption of person lead decisions and informed consent.
- Protection – Support and representation for those in greatest need.
- Prevention – It is better to take action before harm occurs.
- Proportionality – Proportionate and least intrusive response appropriate to the risk presented.
- Partnership – Local solutions through services working with their communities.
- Accountability – Accountability and transparency in delivering safeguarding.

The Government has indicated general acceptance of the recommendation of the Law Commission in making SAPBs statutory. Changes were outlined as part of the draft Bill to modernise adult social care. If the Law Commission's recommendations in relation to safeguarding adults at risk are accepted in total this will mean:

- Confirming Local Authorities as having the lead co-ordinating responsibility for safeguarding adults at risk.
- Placing a duty on Local Authorities to investigate or cause an investigation to be made by other agencies in individual cases.
- Local Authorities will have the power to request co-operation and assistance from designated bodies during adult protection matters and the requested body will have to give due consideration to the request.
- There will be a new definition of an adult at risk.
- The functions of the SAPB will be defined in statute.
- Unless the Government deemed otherwise, there will be no new statutory powers of entry or exclusion orders relating to safeguarding adults at risk
- Section 47 of the National Assistance Act 1948 will be repealed as incompatible with the European Convention on Human Rights.

These requirements have now been included in the Care and Support Bill, so are likely to come into force in 2015

Depending on the statutory scope of the SAPB's work this may have financial implications for LB Hillingdon and partners in needing to support the work of a new Board. Currently the commitment of partner agencies is through officer time and some designated posts. However, LB Hillingdon's adults and children's Boards working with each other will enable efficient use of existing resources.

The NHS continues to evolve and by the end of 2012-13 the local cluster groups will have been replaced by GP led Clinical Commissioning Groups (CCGs) As previously mentioned, interim guidance from the Department of Health is in place to ensure responsibility for safeguarding arrangements for children and adults is undertaken by CCGs

London

The London Boroughs Social Services leads for safeguarding adults form a self supporting network to develop consistent good practice across London. Facilitated by the Social Care Institute for Excellence (SCIE) a Pan-London multi-agency safeguarding adults at risk policy and procedures has been developed and have been implemented in all London Boroughs, including Hillingdon. The policy and procedures introduces a consistent framework by which adults are safeguarded. This will mean having consistent definitions of roles and responsibilities, timescales for responding and promote better partner and cross boundary working.
Currently, work is underway on the development of a pan London data set to measure outcomes in safeguarding. Hillingdon plays a key role in these developments – the Service Manager chairs the pan London officer group and is involved in the development of the data set,
A further piece of completed pan London work has been the development of practice guidance which is to be issued in the Autumn of 2012.

During the year, a London Chair's group was established in order to share good practice and steer developments. The group is chaired by a DASS and reports directly to the Joint Improvement Board, and indirectly through its chair links with ADASS. Although many Boards are chaired by the DASS, there is a growing tendency towards us of independent chairs, especially in those Boroughs which, like Hillingdon, have forged closer links with the LSCB. This group can ensure quicker learning across London and can jointly pick up some emerging themes, self neglect being a recent example

Hillingdon

Children's Services in Hillingdon are planning to implement a Multi Agency Safeguarding Hub (MASH) in autumn 2012. The potential for including the referrals for safeguarding adults at risk are being explored. This is a positive development which will be a high priority for planning in 2012-13

7. WHAT WE NEED TO DO: priorities for SAPB 2012 onwards

Performance activity, local and national learning, plus consultations with staff and partners, have indicated that our priorities are the right ones/ that we should reframe our priorities in accordance with the six key principles. These are detailed below with our planned activities identified under each one.

Priority 1. Empowerment

- Ensure that decisions are person led through informed consent whenever possible
- Staff development and training to remain a priority, and to focus on key identified issues
- Safeguarding adults remains focused on outcomes agreed with service users and this is demonstrated.

Priority 2. Protection

- Pan London procedures safeguarding adults at risk –continue the roll out the new policies and procedures and ensure they are embedded in practice
- Improve our awareness and response to abuse or exploitation originating via electronic means, e.g. smart phones, social websites etc.
- Ensure and improve response to allegations of financial abuse

- Amend recruitment policy and guidance to comply with revised CRB guidance and the Protection of Freedoms Act.

- Implement the recommendations from the Winterbourne Report ,a dn Care Qualities Commission Review of learning disability services.

Priority 3. Prevention

- Evaluate advocacy service
- Consider use of mental capacity advocacy service (IMCA)
- Develop better ways of assessing risk across partner agencies
- Develop better identification and support through MASH
- Increase staff awareness of issues of self neglect and how to respond.
- Increase access to e-learning safer adults awareness training

Priority 4. Proportionality

- Ensure that responses are in accordance with need, are as unintrusive as possible, and that DOL used only as a last resort
- Develop and disseminate local guidance around deprivation of liberty

Priority 5. Partnership

- Develop greater professional responsibility and awareness ("whistle blowing") on poor practice and safeguarding adults at risk.
- Improve awareness raising in the community, particularly through voluntary organisations
- Seek representation of the CCG and GPs as providers on the SAPB

Priority 6. Accountability

- Improve SAPB quality control through case audits and scrutiny of performance
- Develop an outcomes framework to show what difference we are making
- Ensure that lessons are learnt through cases, particularly SCRs
- Implement new risk assessment framework which will enable better measurement of risk reduction through intervention. The inclusion of carer or advocate views will enable this indicator to be more effective in measuring outcomes.

<u>Individual agency plans</u>

Age UK

In 2012 – 13 the organisation's CEO will continue to attend the SAPB meetings and provide resources in terms of staff, skills and experience to the working groups.

We will continue to raise awareness of abuse through campaigns with Age UK and workforce development.

The organisation will continue to work with DASH to deliver an advocacy service for vulnerable adults going through the safeguarding process.

Age UK Hillingdon will work with RRICHH to recruit, train and provide support to volunteers who advocate in care homes in Hillingdon.

In May 2012 we will provide training courses in partnership with Uxbridge College for older people wanting to work in the care industry in Hillingdon, including modules on adult protection and compassion.

Hillingdon Carers Planned initiatives for 2012-2013:

- Review of Criminal Record Check arrangements to reflect reduced policy requirements nationally (within policy guidance locally).
- Develop in-house staff training further to cover carer related issues highlighted by casework.
- Extend face to face information on Safeguarding directly to carers by arranging Bite-sized awareness raising sessions in further venues across the borough.
- At least 1 Safeguarding Vulnerable Adults information campaign to be run within the Carers Advice Centre on Uxbridge High Street.
- Carers Fair 2012 (Mall Pavilions Shopping Mall in Uxbridge) will provide an opportunity for London Borough of Hillingdon to promote Safeguarding messages to the wider public and to more than 30 other organisations present.

. **The Hillingdon Hospital** Actions planned for 2012-13

- Launch of THHFT Safeguarding Strategy

- Learning Disability Awareness survey of staff / re-audit September 12
- Further MCA and DoLs training sessions
- Domestic Violence Awareness sessions (in-house)
- Implementation of a Mental Capacity Assessment and Best Interests Form at the Trust
- To integrate the PREVENT Strategy into Safeguarding agenda wherever possible, as outlined in the Pan-London guidance for Adults at risk.
- The completion and approval of the Self-Assessment tool for PREVENT
- The implementation of a Vulnerable Adults Divider for the patients' medical notes
- Review of the Safeguarding Adults Trust Policy
- Review of the SAAF for vulnerable adults
- To implement an Adults at Risk Form in the Trust as part of the revised nursing documentation. This is to ensure that the appropriate risk assessment is in place and will signpost staff as to what to do and who to contact.
- Formation of a Safeguarding Committee to replace the Adults and Children's Trust Steering Groups.
- To promote the new easy read/pictorial version of the computerised 'real time' patient experience questionnaire, so that the Trust can see where good practice is taking place and where we can improve.

CNWL Proposed Developments

Mental health

Given the feedback from the audit and the fact that adult safeguarding has become more to the centre of activity within the Trust, it is proposed to carry out extensive publicity and awareness training within the Trust over the next 12 months. This will involve significantly increasing the profile around adult safeguarding in the light of the development of the new Trust guidance document. It is planned to have a workshop for Trust staff in October 2012 where the Trust guidance will be launched alongside a presentation on the Pan- London Procedures and Department of Health Clinical Governance guidance. The Hillingdon LA Lead was part of the group who led on the Pan London Procedures and has agreed to present at the workshop.

There also needs to be some discussion about the need to involve users and carers where appropriate and this will be part of the development of a user and carer engagement strategy.

The Quarterly Safeguarding Group will be receiving a report following the completion of visits to all the Local Authorities partners with recommendations that will include the role of clinical accountability and thresholds for safeguarding adult referrals and assessments.

Hillingdon Community Health

(ii) **Actions Planned in 2012-2013**

The team have a number of actions planned for 2012/13

- To ensure that dignity and respect for all patients is embedded into everyday practice
- To ensure that at least 3 audits take place, these will be:
    - Staffs education needs regarding patients with Learning Disabilities
    - Dignity re-audit
    - Safeguarding adults audit focusing on training
- To ensure that training is available and easily accessible for all staff
- To keep all policies up to date and to ensure that all safeguarding policies reflect pan London guidance
- To ensure that the learning disabilities agenda is embedded into practice
- To assure board members that safeguarding adults is taken seriously and that all current legislation is adhered to through audit and through the annual self-assessment assurance framework.
- To assure that GP's have awareness of the safeguarding adults agenda
- Care homes (including domiciliary care agencies) - to recognise and encourage good practice. To identify and help to address potential problems.
- To review pressure ulcer incidents; being involved in appropriate root cause analysis investigations and ensuring that those originating in nursing homes are correctly completed and signed off.

London Fire Brigade

- Safeguarding Adults at Risk training to be undertaken by all fire crews and senior officers within the borough by the end of the year
- The Borough Commander will promote the introduction of a 'self-neglect' category (which includes hoarding) into the Pan London Safeguarding Adults Policy within the LFB as such cases represent those most frequently encountered by fire crews
- Fire crews will continue to report allegations of neglect and abuse to the LB Hillingdon SSD in accordance with our current policy
- The LFB will continue to be represented on the Safeguarding Adults Partnership
- The LFB will continue to provide advice and guidance in relation to home fire safety when appropriate

APPENDIX 1: SAPB membership

Chairman Lynda Crellin -Independent

Local Authority

- Linda Sanders – Director (SCH & H) LBH
- Cllr Phillip Corthorne – Cabinet Member (SCH&H) LBH
- Merlin Joseph – Deputy Director (SCH&H) LBH
- Nick Ellender – Service Manager, Safeguarding Adults at Risk LBH
- Dawn France – Human Resources LBH
- Paul Hewitt – Service Manager, Safeguarding Children LBH
- Marcia Eldridge – Learning & Development Manager (SCH&H) LBH
- Tracy Gallagher – Social Work Lead, LBH Mental Health Services LBH
- Sarah Morris – Head of Older People's Services, LBH
- Dan Kennedy – Service Manager, Performance & Intelligence LBH

Health

- Barbara North – Safeguarding Adults Lead, Hillingdon Community Health
- Maria O'Brien - Deputy Chairman [Managing Director, Community Services, CNWL NHS Foundation Trust]
- Jacqueline Walker – Deputy Director of Nursing, Hillingdon Hospital Foundation Trust
- Anna Fernandez – Safeguarding Lead, Hillingdon Hospital Foundation Trust
- Sandra Brookes – Service Director, Adult Mental Health Services, CNWL
- Ana Paz -Lead Social Worker/ Complex Discharge Coordinator at Royal Brompton & Harefield Hospital Trust Lead
- Dr Helen Neuenschwander – GP Advisor, Safeguarding, Hillingdon Community Health

Police

- Graham Hamilton – Detective Inspector, Public Protection Group, Met Police
- Jacqui Robertson – DCI Community Safety Unit, Met Police

Voluntary Sector

- Angela Wegener – Chief Executive, DASH
- Chris Commerford – Chief Executive, Age UK Hillingdon
- Jill Patel – Director, MIND
- Claire Thomas – Chief Executive, Hillingdon Carers

Other

- Phil Butler – Borough Commander, London Fire Brigade
- Amanda Brady – Compliance Manager, CQC

APPENDIX 2 Safeguarding Adults – summary of activity for annual report.

1. Number of Alerts / Referrals

Alerts	Male	Female	**Referrals**	Male	Female
794	313	481	468	186	285

2. Number and percentage of alerts and referrals by age range

Total	18-64yrs	65-74yrs	75-84yrs	85+yrs
1262	493 (39%)	184 (14.6%)	251 (19.9%)	334 (26.4%)

3. Number and percentage of alerts and referrals by ethnicity

Alerts	All white categories	All non-white categories	**Referrals**	All white categories	All non-white categories
794	635 (80%)	159 (20%)	469	364 (78%)	105 (22%)

4. Main referral sources by category and percentage

Source	All social care staff	All health care staff	Family/friend /public	Other categories
	30%	25%	21%	24%

5. Referrals percentages by nature of alleged abuse

Physical	Sexual	Emotional	Financial	Neglect	Discrim.	Institutional
28%	4.5%	19%	23%	22%	0.5%	3%

6. Referrals percentages by location of where alleged abuse took place

Own home	Care Home	Health setting	Supported accom	Other categories
61%	21%	5%	4%	9%

7. Referral percentages by relationship of alleged perpetrator

Partner or family	Health worker	Social care	Other professional	Neighbour /Friend	Not known	Other categories
38%	7%	8%	9%	8%	8%	22%

8. Percentage of completed referrals by case conclusion

Conclusion	Substantiated	Partly substantiated	Not substantiated	Inconclusive/ Not determined
	29%	1%*	53%	17%

(* Inability to record this category on the data system until much later in the year has depressed this figure.)

9. Acceptance / satisfaction with protection arrangements, as stated by the adult at risk

Yes	No	Could not consent
55%	15%	30%*

(* Lacked the mental capacity to be meaningfully engaged with expressing a view on the outcome.)

APPENDIX 3 SAPB Sub-Groups.

1. Policy and Performance sub-group

Remit:

a) To ensure the London Multi-Agency Safeguarding Adults at Risk Policy and Procedures are embedded in practice across all partner agencies in Hillingdon.

b) To review any new legislation or guidance relating to safeguarding adults at risk and to provide recommendations to the SAPB on any changes in local practice required.

c) To identify areas for improvement in the arrangements for safeguarding adults at risk in Hillingdon and devise ways of implementing these improvements in partnership with agencies.

d) To provide performance activity data to the SAPB, the content and frequency to be confirmed by the SAPB.

e) To carry out an annual partnership audit / self assessment of safeguarding activity based on one or more of the following four themes*

Outcomes for and the experiences of people using the service.

Leadership, strategy and commissioning.

Service delivery. Performance and resource management.

Working together.

f) To identify and disseminate learning from safeguarding adults at risk (e.g. serious case reviews outcomes).

2. Financial Exploitation sub-group (time limited).

Remit:

a) To identify the type and volume of financial abuse referred in Hillingdon.

b) To identify the barriers to successful and timely investigation or prevention of financial abuse in Hillingdon.

c) To establish good practice examples from other areas / agencies.

c) To identify, in an action plan to be presented to the SAPB, what changes should be made to improve Hillingdon's response to financial abuse and which key partners should be involved to achieve this.

d) To undertake the work, with partners, to implement the action plan agreed by the SAPB.

e) To review the effectiveness of changes made by Hillingdon partners in response to allegations of financial abuse.

3. Safeguarding Adults at Risk Learning and Development sub-group.

Remit:

a) To review and confirm the key competencies / learning required for safeguarding adults at risk work at the different levels of involvement in the processes of safeguarding.

b) To ensure safeguarding adults at risk learning across partner agencies conforms to the agreed competencies and is of a consistent standard.

c) To collate safeguarding adults learning and development completed by staff across partner agencies, so there is a total picture of staff who have received training.

d) To identify new safeguarding learning and development needs and devise a partnership response to these needs.

e) To promote "joined up" learning and development across partner agencies in order to maximise budget resources.

f) To provide safeguarding learning and development information to the SAPB as and when required.

4. Human Resources sub-group.

Remit:

(Joint with the LSCB – remit already established.)

Current attendees: Nick Ellender, Dawn France

5. Serious Case Review sub-group.

To be chaired by the chair of the SAPB. Membership must consist of a minimum of Hillingdon Adult Social Services, normally Head of Service level, Met Police at Detective Inspector level, NHS representation at Service Director / Manager level, Legal and CQC.

Remit:

a) To decide whether the particular circumstances of the adult at risk meets the criteria for a serious case review and, if so, to ensure the review is carried out in line with agreed procedures.

b) Where the circumstances do not meet the criteria, to decide what alternative action by partner agencies should take place.

c) To ensure the purpose of a serious case review is adhered to as set out below:

- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard adults at risk.
- To establish what those lessons are, how they will be acted upon and what is expected to change as a result.
- To improve inter-agency working and to better safeguard adults at risk.

Also that any recommended actions arising from the serious case review are considered by the sub-group and decisions made on how they will be implemented.

(* Thematic framework devised in conjunction with SCIE, ADASS, Local Gov Group and the NHS Confederation.)