Hillingdon Safer Adults Partnership Board Annual report 2012-13

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INTRODUCTION

This report covers the work of the Safer Adults Partnership Board (SAPB) during 2012-13. It highlights the main achievements in safeguarding Hillingdon's vulnerable adults, and identifies the priority areas for improvement for the following year and beyond. Any significant developments in the early part of 2013-14 are also included.

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.

We have this year further developed our local processes and procedures and have introduced a new risk assessment framework which should enable us to better assess the effectiveness of interventions. The local response to Winterbourne and Francis enquiries has been robust and timely.

This has also been the first full year of collaboration with the LSCB. 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 and the Francis report, 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 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 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 273,900 at March 2011 (ONS) and a projected population of 281,756 for mid 2012 of which approximately a quarter are under 19.

Numbers aged over 65years old are projected to increase to over 38,614 by 2018 (GLA projection). 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%. The ethnic diversity of the Borough is steadily increasing.

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 2012-13 2480 adults received an assessment from Adult Social care. There were 5561 reviews of existing service users and 3914 people were in receipt of adult social care services.

Lynda Crellin

Independent Chairman

June 2013

1. WHAT WE HAVE DONE

What we planned to do – our key priorities

WHAT WE SAID WE WOULD DO	WHAT WE DID
Empowerment	
• Ensure that decisions are person led through informed consent whenever possible	• User's and/or their representative's views are specifically referred to as part of investigation reports, case conference minutes and in the closure summary • Increased attendance of service user and/or their representative at case conferences • Increased use of "best interests" meetings to ensure wishes and preferences of service users are considered.
• Staff development and training to remain a priority, and to focus on key identified issues	• Increased training opportunities within partner agencies. • Training completed to address key area of mental capacity. • For social workers, development of the professional competency framework and membership of the College of Social Work to underpin practice
Protection	
• Pan London procedures safeguarding adults at risk – continue the roll out the new policies and procedures and ensure they are embedded in practice	• Policy and procedures available on line to all agencies along with good practice guidance. • Continuing with programme of briefings to ensure alerting staff and managers are clear of their responsibilities. • Amendments to the policies and procedures in progress to reflect structural changes in Health and the Police. • Continued engagement with the London Network on ensuring good practice and partnership working and that policies remain relevant.
• Improve our awareness and response to abuse or exploitation	• Learning from individual cases disseminated.

originating via electronic means, e.g. smart phones, social websites etc.	• Working towards a more comprehensive training package to increase staff confidence and knowledge in this area.
• Ensure and improve response to allegations of financial abuse	• More proactive prevention of financial abuse by management of service users' finances through Deputyship (74) and Appointeeship (221) • Financial abuse being identified in 26% of referrals. • Need to do more in cross agency working with the private sector.
• Implement the recommendations from the Winterbourne Report ,and Care Qualities Commission Review of learning disability services	• All Winterbourne relevant cases reviewed to ensure safe care as first phase of the action plan. • Multi-agency action response plan agreed and being carried forward under SAPB monitoring
• Amend recruitment policy and guidance to comply with revised CRB guidance and the Protection of Freedoms Act.	• This has been carried forward to 2013-14 although all agencies have been updated on the implications of the various changes
Prevention	
• Develop better ways of assessing risk across partner agencies	• New risk assessment framework developed and implemented to enable better assessment of outcome in terms of increased safety
• Develop better identification and support through MASH	• Began work towards developing Multi Agency Safeguarding Hub (MASH) which will include vulnerable adults. • Implementation date September 2013
• Increase staff awareness of issues of self neglect and how to respond.	• Self neglect protocol developed and agreed and disseminated across agencies. Panel to be set up linked to this and hoarding behaviour
• Evaluate advocacy service • Consider use of mental capacity advocacy service (IMCA)	• Evaluating use of advocacy service in safeguarding deferred due to re-tendering of the contract. • Use of the mental capacity advocacy service identified as

	low. To raise awareness across provider agencies through training workshops.
• Increase access to e-learning safer adults awareness training	• 168 social care staff completed training. • 138 social care staff have enrolled to complete the training.
Proportionality	
• Ensure that interventions are carried out in a way that is proportionate to the circumstances presenting and achieve the desired outcomes in the least intrusive way. • Develop and disseminate local guidance around deprivation of liberty and restraint	• Local guidance on deprivation of liberty developed and disseminated with joint working with the Hillingdon Hospital Trust to improve practice. • Safeguarding Team Managers review closures of SA processes to ensure appropriateness. • Reviewed the proportion of cases progressed are consistent with comparable Boroughs and representative of the community.
Partnership	
• Improve SAPB quality control through case audits and scrutiny of performance • Develop an outcomes framework to show what difference we are making	• Assessed SAPB functioning using ADASS outcomes framework • Improved access to real time performance data • Further work needed to evidence the level of positive outcomes.
• Ensure that lessons are learnt through cases, particularly SCRs	• Redrafted local Serious Case Review guidance • One case reviewed using SCR methodology
• Seek representation of the CCG and GPs as providers on the SAPB	• Representation on the Board from Clinical Commissioning Group (CCG) agreed and put in place. GPs a providers followed up through lead GP
Accountability	
•	• Each agency regularly reports to SAPB and through annual report on progress against objectives
	• Health SAAF reported to Board and actions updated on exception basis

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.

Attendance at the Board was good during the year with CNWL Community Health, Hillingdon and Brompton Hospital and DASH and Council services all achieving 100%

75% attendees were Hillingdon Carers, London Fire Brigade, and Hillingdon Community Health.

50% attendees were Borough and Metropolitan Police, HR (LBH), Age UK and Adult Mental Health had 50% attendance

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

From April 2013 the Clinical Commissioning group (CCG) is represented on the SAPB by the Lead GP and the Executive Lead for Adults.

When the Government's intentions are clear with regard to the Care Bill, we will review and update the membership and terms of reference of the Board.

Independent chairman

Since November 2011 the SAPB has been chaired by an independent chair, who also chairs the LSCB. More local authorities are moving towards independent chairing, especially those who have returned to a combined

children and adult social care system. In March 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, along with training activity 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 Adult Social Care (statutory DASS) sits on the Board and the annual report is presented to Council's Policy and Overview Committee and to Cabinet.

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. The partner leads also act as the champion for safeguarding adults in their organisations. In addition, the safeguarding service works closely with LBH's contracts inspection team, and with the Care Quality Commission (CQC).

LB Hillingdon in 2013 is reconfiguring the adult social care pathway to ensure unnecessary duplication and barriers to effective cross working are eliminated. For example, for adults with disabilities this has taken the form of an "all age" service that looks to smooth the transfers from childhood to adulthood. Similarly, with the service for older people, new ways of working seek to increase contact time with service users, provide more responsive, timely assessments and reviews and to offer better care solutions.

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

Age UK Hillingdon is committed to the protection of vulnerable adults. The organisation has reviewed a range of policies and procedures to ensure that Safeguarding is given a high priority within the organisation and to provide its staff and volunteers with the confidence and knowledge to identify potential abuse and act on it appropriately:

These policies are included in the Staff Handbook, highlighted as part of the induction training of all staff and volunteers and reinforced through

safeguarding training. Safeguarding is a standing agenda item for staff and volunteer meetings and is included in our Supervision and Appraisal forms.

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

Main achievements 2012 - 2013

Age UK Hillingdon and Hillingdon Carers worked together to provide a support group for relatives of residents in care homes in Hillingdon (RRICHH). Volunteers recruited through RRICHH were trained to act as advocates for people living in care homes in the borough. The Black and Minority Ethnic 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’s Human Resources Manager has been an active member of the Safeguarding HR Sub Group.

Main Challenges/developments

500 volunteers and staff work for Age UK Hillingdon to support older people with the organisation and each volunteer will have training on safeguarding adults as part of their induction. Ideally they should each be provided with regular on-going training on safeguarding however it has been hard to access affordable training in this area. The organisation has therefore recently reviewed its policies and procedures and will raising awareness of these with all staff and volunteers so that there is a clear process for reporting abuse.

Disablement Association Hillingdon (DASH)

DASH is a disability charity and works with many vulnerable people on a daily basis. We have strong policies and procedures and have regular training to ensure that all staff are fully aware of the need to understand and follow the procedures.

We have advocates who work with people who are going through the safeguarding process to ensure that they are fully supported through the interviews and that their voices are heard.

We follow safer recruitment procedures and all staff and volunteers are CRB/DBS checked.

Through our direct payments work with the Council we also assist people employing Personal Assistants to follow safer recruitment procedures and CRB check the people they choose to employ.

With new procedures for DBS checking it will be more difficult in the coming year to ascertain at what level we can check our staff and volunteers. In the past everyone could be checked at enhanced level but as we are not involved in personal care this will be less clear cut particularly for our sports sessions. It is our intention to check at the highest level permitted but to ensure that we maintain our safer recruitment procedures to ensure we have full references and work history.

It is our intention to continue to educate the people we work with to ensure that they understand what safeguarding means and to expect high standards

from people who are working with them. We will also encourage them to raise concerns if they feel they are at risk.

Hillingdon Carers

Internal arrangements

During 2012-13 a review of internal arrangements has been commenced in response to changes arising from the Disclosure and Barring Service requirements. This has resulted in:

- Changes to safer recruitment arrangements to ensure levels of checking are appropriate in relation to employee roles;
- Review of processes in relation to recruitment and on- going checks for volunteers;
- Refinement of role descriptions and defining the scope of roles to ensure practice reflects current legal frameworks;
- Review of *Hillingdon Carers Safeguarding Vulnerable Adults Policy* to ensure the policy reflects Pan London policies and guidance.

Over the year 2012-13 Hillingdon Carers has continued:

- Specific inclusion of *safeguarding issues* in every staff supervision (including administrative staff responding to telephone and e-mail contact from our clients);
- *Regular training* for all staff/volunteers who have regular, unsupervised contact with children and/or vulnerable adults (one third of staff completed e-learning update during year);
- *Safeguarding prompts* on all assessment documentation/checklists for casework with young carers and adult carers supporting vulnerable adults;
- *Centralised record* includes referrals to local authority safeguarding team.

HEALTH AGENCIES

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

The Hillingdon Hospitals NHS Foundation Trust

Internal governance arrangements in respect of adult safeguarding

Safeguarding Adults arrangements at the hospitals have continued to strengthen during 2012/13. The Executive Director for safeguarding, who sits on the hospital Trust board oversees the annual work and audit programmes for safeguarding adults and progress against these is now reported to the Trust's Safeguarding Committee which reports to the Quality and Risk Committee (a board committee) on a quarterly basis. An annual report on safeguarding activity was presented to the Trust Board in August 2012.

The Trust has a multi agency Safeguarding Committee, which meets on a quarterly basis and covers both adults and children safeguarding work. This replaces the Safeguarding Adults Steering Group (SASG).The Committee is chaired by the Executive Director of the Patient Experience and Nursing.

The Self Assessment Assurance Framework (SAAF) 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'. The SAAF was validated at a multi-agency event chaired by NHSL in September 2012.

The Trust was also involved in the validation of the Learning Disability SAAF. The Trust section of the SAAF was validated.

Both of these tools provide the Trust with substantial assurance in terms of safeguarding governance; both Are reviewed bi-annually at the Safeguarding Committee . There is a strong working relationship with both Clinical and Information Governance at the Trust in relation to Safeguarding.

There is also regular attendance at the Hillingdon PREVENT Partnership Group.

The Hillingdon Hospitals NHS Foundation Trust's contribution to and achievements in improving safeguarding during 2012-2013

The Trust hosted the third 'Benchmark of Best Practice' workshop in April 2013. The event allows Trust staff to engage with service users and carers and with colleagues from local health, social care and voluntary sector organisations to benchmark our services for patients with a learning disability and for people who are vulnerable against the NHS London Benchmark of Best Practice tool. The most recent event was attended by nearly 100 people. The event focused primarily on the experiences of patients and service users accessing services at the Trust, including a multi agency case study on the care of a person with severe learning disability and very complex health needs and two people with autism talking about their condition. A summary on Dementia care at the Trust and the Equality Delivery System was also provided.

The Trust has been referenced again in March 2013 in the NHSL (now NHS England, London Branch) Pan-London Thematic review of the SAAF as an example of good practice, in relation to listening to and acting on user views.

The Trust 'Safeguarding Matters' newsletter for adults and children is sent to staff, on a regular basis.

In 2012/13, there was re-audit of staff knowledge and awareness of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (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 conducted on Learning Disability awareness and of vulnerable patients focussing on how the Trust staff look after these patients in hospital. The results were positive; staff knew who to contact if there were concerns. There needs however, to be increased awareness and use of the patient passport.

Key challenges moving forward in 2012/13 include:

- The achievement of more than 80% compliance with Safeguarding Adults training.
- A greater understanding and embedding of MCA and DoLS

Central and North West London Health (CNWL)

CNWL NHS Foundation Trust CNWL is one of the largest trusts in the UK, caring for people with a wide range of physical and mental health needs. We provide healthcare to a third of London, Milton Keynes and parts of Kent, Surrey and Hampshire. Within the borough of Hillingdon, CNWL provides both mental health and community care services, (the latter is known as Hillingdon Community Health).

In relation to the community services provided in Hillingdon by CNWL:

Hillingdon Community Health

Governance arrangements in respect of adult safeguarding

In 2012, Hillingdon Community Health was able to declare full compliance with safeguarding responsibilities as outlined in Outcome 7 of the Care Quality Commission's Essential Standards of Quality and Safety.

The community division holds a quarterly safeguarding meeting, chaired by the Managing Director for Community Services, to review policies, results of audits, training plans, lessons learnt from safeguarding alerts as well as agreeing and overseeing the annual work plan.

Representatives from the community division also attends the Trust's Quarterly Safeguarding Committee which is chaired by the Board Level Safeguarding Lead - Executive Director of Operations and Partnerships.

As a key borough partner, there is Director level representation from the community division on the local Hillingdon Safeguarding Partnership Board with representation also on the sub-groups which support the Partnership Board.

Main Achievements 2012-13

During 2012/13, the community division completed the London-wide Safeguarding Adults Self Assessment Assurance Framework (SAAF). There was evidence to show good performance across all of the indicators with only two amber rated (Mental Capacity Assessment and PREVENT). Since the initial assessment, the community safeguarding lead has undertaken significant work in relation to both these areas and the division is now rated as "green."

During 2012/13, three detailed audits related to adult safeguarding were undertaken:

Learning Disabilities – this focused on the quality of care planning and evidence of reasonable adjustments being made for this vulnerable group. Overall, the results found that care planning was good with reasonable adjustments for individual patients identified. Recommendations were made around improving care plan review dates and a planned re-audit is scheduled

for 2013/14. This audit positively reflects the significant work which has been undertaken as a priority for the division during 2012/13 which comprised training for staff, development of further easy read literature and the designing of bespoke care planning tools for staff.

Dignity - this audit was undertaken to assess (from a patients perspective) whether they felt that they had been treated with dignity and respect. The audit showed a very positive outcome with patients feeling that they are listened to, respective and involved in decisions about their care.

CNWL Mental Heath Services

Introduction

Information about the areas the Trust serves, our internal governance arrangements for safeguarding children, updates on last years planned actions and plans for 2012/13, together with the revised approach to training is included in the CNWL Safeguarding Children Annual Report 2011/12. The link to this on the web is:
http://www.cnwl.nhs.uk/Board_Directors_papers.html. The paper is listed under the Meeting of 11th July 2012.

Please see below the Mental Health and Allied Specialties contribution:

1. Main Achievements 2012/13 have been:

- **Establishing shared supervision arrangements**: Addiction Services have agreed times when safeguarding children cases can be presented to CSC workers for support and challenge.
- **Young Carers**: The CNWL Safeguarding Children's Advisor has worked with local partners to develop a training package for staff to raise awareness of young carers issues. CNWL has also established a Focus Group for Young Carers so that they can feedback their views on services and what improvements would make a difference to them. Hillingdon Young Carers have been present in this group.
- **Section 11 Audit**: The Trust completed a Section 11 Audit for Hillingdon and an evidence file documenting the supporting evidence of compliance was made available. Where further work was needed an action plan was developed and these actions have all been completed.
- **Supervision Audit across adult and CAMHS** – carried out by external auditors. This found all staff had been supervised with their CP cases in the previous month, the main learning point was the need to record the safeguarding children supervision on the electronic record, and to update the Supervision Policy so guidance was clear on this. **Safeguarding Helpline Audit**- showed that service in Hillingdon used this on a regular basis and there was a high level of awareness amongst staff on how to access support on safeguarding issues.
- **Attendance at safeguarding training including refresher training** – presently CNWL level of attendance on training is above 85% and the Trust is fully compliant with the David Nicholson DH requirements on this. CAMHS and staff who regularly see children received training on the CAF.

2. Main Challenges

We have identified some key challenges for the Trust in 2012/13:

- **Reviewing CAMHS**: Commissioners have been working with CAMHS to review the service and concerns remain within CAMHS about the level of funding and capacity to meet local needs. A Royal College of Psychiatrists review identified some areas to strengthen also potential gaps in commissioning.
- **The financial environment** and the impact on contracts with CNWL may mean that services have to reduce and may not meet the needs of children, the demand of families or the expectations of partner agencies.
- **Impact of the benefit changes** on families may result in moves of families where there are concerns and disrupt treatment packages, or risk being lost to the systems in new areas. The areas where families may move from to Hillingdon are likely to be managed by CNWL, so this risk is mitigated.
- **Establishing information systems to gather the information needed**, that is, to collect more outcome focused measures and qualitative data to assess the effectiveness of services, including linking adults and children in the IT system. Many of the IT systems do not currently support the collection of such information.

Royal Brompton & Harefield NHS Foundation Trust

Outline of Trusts Governance arrangements in respect of Adult Safeguarding.

The Trust has an Executive Safeguarding Lead that reports directly to the Trust Board and supports the Trust' Safeguarding Lead to:

- Deliver strategic objectives and lead across the service, supporting individuals and departments in their engagement in safeguarding cases and providing advise on safeguarding escalations and Investigations
- Work collaboratively with community health and social care partners, reporting and attending Local Safeguarding Partnership Board Meetings
- Prepare Trust-wide annual reports of safeguarding adults Activity and coordinating internal meetings. The Safeguarding steering group has merged with the newly established Mental Health and Safeguarding Committee where the safeguarding agenda is disseminated and there is an opportunity to allocate time for case reviews. This committee reports directly to the Governance and Safety Committee which selects items and takes them to the Risk and Safety Committee (a non-executive committee of the Trust Board)
- Ensure training content is in line with national guidelines and local requirements.

Furthermore the Trust has a local policy in line with national guidance that includes the Pan London Policy and Procedures, Prevent Strategy and Savile allegations requirements. The Policy outlines the referral process and roles and responsibilities of all staff.

Main achievements in 2012-13

Achieved 90% of the set target for safeguarding mandatory training. Continue to strengthen the training strategy for all areas of safeguarding: Level 2 “The referring manager Role” was commissioned and brought in-house from January 2013; Mental Capacity Act tailored “Understanding the legal use of restraint” training was set up to improve safeguarding measures and provide guidance and processes to govern the use of restriction and restraint and to understand the Mental capacity code of practice.

Launched the Prevent Strategy in line with government guidelines to address radicalisation and stop people becoming terrorists or supporting terrorism.

Completed the 2012 NHS Operating Framework for Adults at Risk (known as SAAF- Safeguarding Adults Assurance Framework). Received good outcomes.

Well established links with tissue viability which has made it possible to implement the pressure ulcer/safeguarding reporting protocol (designed by the K&C Safeguarding partnership board).

Main challenges/developments

Continue to develop and guidance and processes to govern the use of restriction and restraint in the context of safeguarding.

Ongoing work with regards to patient, users and carers involvement with regards to safeguarding. The following areas are still developing and need improving: collecting the evidence

Development of a Mental Health and Safeguarding board, platform to discuss serious case reviews.

Metropolitan Police

1. MPS governance regarding Safeguarding Adults at Risk is contained within:

1. **S.O.P. Investigations into Domestic Violence**
2. **S.O.P Investigations into Disability Hate Crime**
3. **S.O.P. Safeguarding Adults at Risk**

These policies introduce 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.

2. The Safeguarding Adults at Risk Unit (S.A.R.) based at West Drayton Police Station has worked throughout the 2012/13 period weekly if not daily with Hillingdon Adult Social Services (A.S.S.) on joint investigations , strategy

meetings and interventions as well as supplying A.S.S. with advice re referrals where necessary.

The most prominent investigation was the conviction of a member of staff for poisoning six dementia in a care home. This was a protracted complex investigation that resulted in three years imprisonment . The case was reported locally, nationally and reported on national television news.

A further focus visit by the Uxbridge Gazette highlighted the innovative work of the Safeguarding Adults at Risk Unit at West Drayton.

3. The retaining of the SAR unit under the new London Policing Model ,LPM which goes live on 24th of June 2013 in Hillingdon Borough.

4. 2013-14 ,The SAR unit retains functionality under LPM within the C.I.D. command based at Uxbridge Police Station with two dedicated Detective Constables

5. The CSU has conducted throughout 2012/13 training in care homes for staff and managers where flawed procedures have been identified .A further presentation for the other 30 CSU managers was held at New Scotland Yard highlighting the work and investigation techniques of the Hillingdon SAR Unit.

London Fire Brigade

1. Hillingdon Borough has 4 Fire Stations with 160 operational personnel. All of these have received internal training in Adult Safeguarding protocols and Child Safeguarding.

2. The London Fire Brigade has dedicated policies covering ‘adult safeguarding’ and a separate one for children and this details what to do and how to recognise the signs. It also explains the reporting mechanism and the timescales involved.

3. Over the last year local crews identified 5 ‘adult safeguarding’ cases and as far as I am aware all of these were known to social services. One child referral was sent through. Again, social services were aware of this family but there had been a deterioration in conditions since their last visit. Thus this identified to me that crews were correctly identifying some of the most vulnerable people in the community and that these had already been picked up on by social services and were being assisted.

4. Crews carried out 2647 ‘Home Fire Safety Visits’ across the borough last year. Although this is not directly linked to safeguarding, we are accessing some areas that some other partners are not. Through our visits we target those most at risk within the community.

5. We fitted 5 arson proof letter boxes to those that may have been at risk of an arson attack. This is work we do with social services or the police or internal departments. Some of these are where there has been a separation of the husband and wife and one has threatened the other with an arson attack.

6. We supplied two sets of flame retardant bedding to two individuals known to us.

7. We assisted the Police, local council and bailiffs with an eviction in March 2013. The person being evicted claimed that he would set light to his property if evicted and this could have endangered his neighbours. For this we were on hand to supply smoke alarms for the neighbours and supply some flame retardant bedding to the council to use for the person being evicted in his new property.

London Ambulance Service

The London Ambulance Service are not currently members of the Board, but have London wide identified various actions arising from the Winterbourne Review:

- Reviewing contracts, to make whistle blowing a condition of employment.
- Developing "Easy Read" complaints information.
- Exploring how best to collate and share safeguarding alerts from same location with LA.

All actions identified from the review will be monitored by the LAS Safeguarding Group and will be added to the LAS Safeguarding Adult Action plan.

Care Quality Commission

Safeguarding 2012- 2013

Background

The Care Quality Commission is the single, integrated regulator for health and adult social care in England to ensure care services are meeting government standards. This includes services provided by the NHS, local authorities, private provider companies and voluntary organisations – whether in hospitals, care homes or in people's own homes. Part of CQC's remit is also to protect the interests of people whose rights have been restricted under the Mental Health Act.

CQC Improvement Activities 2012-13

Over the last 12 months we have continued to improve our systems and process in response to lessons learnt from high profile cases. Significant development work has continued across CQC's safeguarding systems and processes. This work includes;

- Revising and publishing our safeguarding protocol
- Development and implementation of safeguarding quality assurance systems
- Development of tools that allow us to improve the interrogation of safeguarding information

Completed all the safeguarding recommendations arising from the CQC Individual Management Review (IMR) arising from the preparation for the Serious Case Review into the events at Winterbourne View

Partnership Working

In our revised safeguarding protocol we have strengthened our commitment to develop working relationships with local safeguarding partnerships. We are committed to attend appropriate safeguarding strategy meetings and local safeguarding boards at least once a year to share regulatory information, promote the role of CQC in safeguarding or discuss a local or regional safeguarding matter. CQC meets with the safeguarding leads from the Association of Directors of Adult Social Services on a quarterly basis to share information and discuss regional and national safeguarding issues.

Winterbourne View

CQC has completed all the safeguarding recommendations arising from the CQC Individual Management Review arising from the preparation for the Serious Case Review into the events at Winterbourne View. We have already made significant changes to various areas of our work that includes ensuring that we are better placed to respond to concerns of whistleblowers in order to protect vulnerable people. Other changes relate to the way we follow-up on action plans when services aren't meeting national standards, build new ways to work with local safeguarding teams and develop the way we analyse safeguarding information so we can spot trends in care.

CQC is also contributor to the Department of Health Concordat – Programme of Action devised in response to Winterbourne View. The concordat commits a range of agencies and public bodies to a programme for change to transform health and care services and improve the quality of the care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges to ensure better care outcomes for them.

Findings from Inspections

Our inspections of safeguarding (Outcome 7) in 2011/12 found that 90% of NHS hospital-based services and 89% of community services met the standard. We found that information-sharing in respect of safeguarding needs improvement in NHS services – there can sometimes be a lack of clarity about responsibilities and procedures, so that some cases are not referred to local authority safeguarding teams where it would have been appropriate to do so. NHS mental health, learning disability and substance misuse services performed less well than other NHS services.

Some independent healthcare services performed fairly well in 2011/12 in respect of safeguarding people from abuse – of those CQC inspected, 90% of independent hospitals and community services met the standard in

the year However, this was not replicated in independent mental health, learning disability and substance misuse services – here 73% of the services inspected met the standard.

There were less positive findings in relation to safeguarding in nursing homes and residential care homes. Of the locations inspected, 83% of nursing homes and 88% of care homes met the standards in 2011/12.

In the first dental care inspections 93% of dental services inspected met the standards on safeguarding and safety. Overall inspectors found good

awareness of child protection issues but providers understanding of safeguarding vulnerable adults were patchy.

NB. This report presents the national picture. Discussions are underway locally to discuss how CQC local work can be represented.

Financial arrangements

The Coalition Government has indicated in the draft health and social care (now 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 have enabled efficient use of existing resources.

Sub groups

Most activities relating to the SAPB business plan have been led by the Service Manager supported by sub groups, mainly established in 2012. Human resources (joint with LSCB)

- Policy and performance
- Learning and Development
- Serious case Review sub group (ad hoc as required)
- Financial Exploitation (short life group commenced in 2013)
- Winterbourne sub group (short life group commenced 2013)

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

3. LEARNING FROM CASE REVIEWS AND AUDITS

Serious Case Reviews (SCRs)

LB Hillingdon had no serious case reviews in 2012-13. National evidence showed some lack of consistency in use of criteria and methodology, so the SAPB reviewed and updated local procedure and guidance in line with recommendations from ADASS and in accordance with the draft requirements of the care and support Bill

The Board did carry out one case review, using the SCR methodology. This review was completed in summer 2013 and concerned a person with varying capacity about whom professionals could not agree about their degree of competence

Those who carried out the review agreed that this sort of situation presented huge challenges for professionals in terms of assessing capacity and risk and that the recommendations and plan should form a substantial element of the SAPB work plan for 2013-14,

In addition to individual agency recommendations, the multi agency recommendations were:

- Raise awareness of Mental Capacity Act; how and when to use, clarification of when a ‘best interests’ meeting is appropriate and risk management of people with varying capacity. Assessment to include risk of fire in the home (working smoke alarm/home living environment/cooking habits).
- Have in place agreed thresholds for review of care plan for somebody with fluctuating capacity. Ensure robust risk assessment tools are in place to identify risks and to be clear what strategies are put in place to address risk and what monitoring of that risk is in place.
- Improve discharge planning process for people with complex needs and varying capacity including consistency in assessment of decision specific capacity. To specifically address in respect of multi agency working and information sharing
- Maximise the effectiveness of the integrated care pilot for people with complex needs and varying capacity.
- Ensure staff and front line managers are aware of decision making process contained in the London SA procedures concerning when to refer to the safeguarding team.
- Ensure all available community safety options are included in all assessments, where appropriate.

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. Referrals from Mental Health Services have increased.

4. WORKFORCE

Whilst safeguarding adults is the responsibility of all staff, the Safeguarding Adults' team is responsible for investigating and managing reports of abuse, except where a criminal offence is believed to have occurred where the Police take the lead. In the LB Hillingdon Safeguarding Adults' team there are currently 12 qualified social workers (10. 5 full time equivalents) 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. 168 social care staff have completed this module and 138 have registered to access this learning module.

Understanding mental capacity and working within the code of practice of the Mental Capacity Act 2005 is an important aspect of safeguarding the adults we work with, whilst maximising their choice and independence. Training for front line staff was completed by 102 staff over four sessions and 23 managers were provided with training to promote good practice in capacity assessments.

Training activity across agencies

The Hillingdon Hospitals NHS Foundation Trust

Safeguarding Lead, (which included a presentation at Level 1 mandatory training in Vulnerable Adults is delivered monthly with an additional 30 minute awareness session on Learning Disability. In addition, monthly training at level 1 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 the surgical audit meeting) and by the Psychiatric Liaison Consultants based at Riverside. A domestic violence session has been delivered to Trust staff by Hestia.

CNWL – HCH

A Safe and Effective Workforce

All HCH staff who may potentially have contact with clients at risk attend Hillingdon's safeguarding adults in-house, mandatory training programme. Sessions are offered at least once every month. Compliance with attendance on this mandatory training programme, including refresher training, is monitored monthly and has been consistently high between 86-95% throughout the year as shown below:

Training Level	Summary of Course	Audience	Trainer	Compliance
Investigators Training	This is a higher level course aimed at staff who may be asked to take a part in safeguarding adults' investigations.	Safeguarding adults team	Social Services	100% completed
Level 2	Referrers training. This is to ensure that anyone working closely with the public can identify adult abuse and will be confident to refer an adult to safeguarding.	All clinical staff	HCH's Safeguarding Adults Team	85% completed
Level 1	Alerters' training. This is to raise awareness about abuse of vulnerable adults. The training gives direction to staff on what signs to look for and who to tell if they identify abuse.	All clerical staff	HCH's Safeguarding Adults Team	97% completed

Between April 2012 and April 2013 70 admin attended Level 1 alerters' training, and 199 clinicians attended level 2 Referrers training.

The community safeguarding adults' team delivers training for Mental Capacity Assessment to all staff. There were 4 sessions during 2012/13; the team has given dedicated MCA and Deprivation of Liberty Standards (DoLS) training to staff working at the Northwood and Pinner Intermediate Care Unit, also the community matrons. The safeguarding adults' team also attends team meetings and discuss safeguarding adults' case studies with the teams; these case studies always include mental capacity.

In line with Trust Policy, all staff working with vulnerable adults have enhanced Criminal Records Bureau Checks undertaken before being allowed to commence in post; this is closely monitored via the Human Resources Department and the division is fully compliant in this area.

HCH Training – this audit was conducted over a 6 month period to assess the effectiveness of training delivered by the safeguarding adults team. The audit was conducted anonymously over a 6 month period. The results were positive with staff feeling that the training met their needs and was geared to their work place. Comments received from some returns have been incorporated into the new training plan for 2013/14.

Brompton and Harefield

The Trust delivers level **1 "Raising *Awareness"*** which focuses on developing a shared understanding with what is abuse and what constitutes an adult at risk; an understanding of the signs and symptoms of abuse. Also what to do if you witness abuse or are told about it. **Level 2 "*The Referring***

***Manager Role"*,** focusing on dealing with disclosures for those who need to complete the alert form as part of their professional role; determining risk, vulnerability and seriousness; examining the implications of the three 'C's – capacity, consent and confidentiality and to understand dignity and respect when working with individuals.

Level 1 is provided through corporate induction sessions and as classroom training and level 2 is provided as classroom training only.

Furthermore we have now developed an in-house e-learning tool, mainly used by the medical teams but opened to all trust staff.

The figures below show training for the period 1/4/12 to 31/3/13 684 people received SGA training of which; 331 Level 1- Induction 337 Level 1- classroom 36 Level 2- classroom By staff group: Level 1: Nurses 263, Doctors 83, Other Clinical 193, Non-clinical 109 Level 2: Nurses 27, Doctors 1, Other Clinical 5, Non-Clinical 4 **This represents 90% of the set target of 726.**

Prevent Strategy training: 13

Age UK

Safeguarding Training 2012-13

The following training has been completed by our staff and volunteers, where appropriate:

- DBS - Duty to Refer
- Safeguarding Adults – e-learning
- Safer Recruitment
- Safeguarding Policy
- DBS – Counter signatory Training

Hillingdon Carers

Hillingdon Carers has continued to contribute to raising awareness of the need to safeguard vulnerable adults and helping the general public report abuse and access support services by:

- Maintaining a *'Report Abuse' prompt* on the home page of Hillingdon Carers website www.hillingdoncarers.org.uk throughout the year;
- Displaying posters from the *Safeguarding Vulnerable Adults campaign* in the Carers Advice Centre in Uxbridge High Street;
- Including *safeguarding issues* in all Carer Awareness sessions delivered to professionals (34 sessions in 2012-13);
- Making a presentation to the joint LSCB-SAPB meeting in March 2013 to raise awareness to a multi-agency audience of *potential*

safeguarding issues related to Young Carers and the family members they support.

- Inviting a safeguarding lead from Hillingdon Community Health to attend two events for carers in primary care venues in the north of the borough during 2012-13.

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 were able to receive 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

Key Information - Safeguarding Performance.

LB Hillingdon provides an annual return to the Department of Health on safeguarding adults' activity. The highlights from these returns for 2012-13 are presented below with commentary and comparison with 2011-12. Percentages, where quoted, are rounded up or down.

Referrals

Alerts	Referrals	Repeat referrals	Completed referrals
825	523	68	538

Alerts are safeguarding contacts made to LBH that do not progress further under SA procedures and referrals are contacts made that do progress. Repeat referrals are where a previous contact has been made and progressed in the same year and completed referrals are those progressed that have been completed in the year, although some may have started in the previous counting year e.g. March 2012.

Alerts and referrals amount to 1,348 which is up 7% on last year. The percentage progressed under SA procedures remained about the same although the total is up on last year. Repeat referrals are low, which is a good indication that SA concerns are being dealt with first time. Despite the increase of total SA contacts, the percentage of completed referrals has increased slightly to 40%. Existing staffing resources have managed this increase in activity.

The gender of contacts remains consistent with last year. Around 60% of contacts are for women and 40% for men. The number of women alleged victims of abuse increases with age. In the 18-64 years group it is 51% and in the 75 years plus group it is 71%.

Ethnicity of Contacts

Alerts	White	Non-white	Referrals	White	Non-white
786 (ethnicity recorded)	79%	21%	522 (ethnicity recorded)	79%	21%

These figures are little changed from 2011-12. Release of the National Census figures for ethnicity profiled by Borough and age indicate, in the 65 years plus age group, 84% are white and 16% are non-white. Two thirds of contacts concerning safeguarding adults relate to people over 65 years old, so the profile seems reasonably matched to the Borough profile. The contacts relating to ethnic minority groups that progress to a referral remains consistent, indicating the screening process does not unintentionally disadvantage people.

Main source of Referral

Social Care staff	Health Care staff	Self/Family and Public
33%	19%	21%

Compared with last year there has been a slight increase from 30% to 33% in social care staff reporting abuse, a 6% decline in health staff and the self/family/public percentage has remained steady at 21%.

Nature of Alleged Abuse

Physical	Sexual	Emo/Psych	Financial	Neglect	Discrim	Institut
28%	6%	17%	26%	22%	0%	2%

Compared with last year’s figures there has been little change with a small increases in sexual and psychological abuse by 2% in each category, a 3% increase in financial abuse and physical abuse and neglect remaining exactly the same.

Location of alleged abuse

Own Home	Care Home setting	Supported accomm setting
55%	19%	7%

The number of people allegedly abused in their own home has decreased slightly from 61% to 55% compared with last year. It is difficult to know if this is good news, being an overall drop in this setting (a difficult area to monitor) or whether the drop is due to non-reporting. Care Home settings are down from 21% to 19% although supported accommodation is up by 3% representing the growth in this type of service option.

Main Perpetrator categories

Strangers/unknown	Social Care staff	Partner/Family Member	Neighbour /Friend
18%	15%	34%	10%

As in previous years, the highest category of perpetrator is someone already known to the person at risk with family, partner, neighbour and friend accounting for 44% of referrals. This is down by 5% on last year. The next category is social care staff 15% of which the majority are domiciliary care staff. This would be in keeping with the large volume of social care provision consisting of domestic support to people in their homes. Abuse from strangers or people unknown constitutes 18% of referrals. The remaining 23% are other professionals, other service users or health care staff.

<u>Case conclusion</u>

Substantiated	Partly substantiated	Not substantiated	Inconclusive
31%	6%	44%	19%

The overall number of cases reaching a conclusion has increased from 478 to 531, an increase of 10%, The percentage substantiated has gone up by 2%, partially substantiated by 5% and there has been a decrease in not substantiated by 9%. Inconclusive has risen slightly by 2%. Overall, this trend is pleasing as the service is being increasingly challenged, whether by individuals or social care providers on the validity of evidence to support our conclusions. This would indicate our investigations are robust.

<u>Outcomes</u>

In the majority of cases there is “no further action” which is slightly misleading as it implies nothing has been done when, in fact, the circumstances of the individual might have been put “back on track” and existing support refocused. The next largest category is increased support (26%) followed by a cluster of categories such as removal to another setting, different care arrangements or arrangements to manage the person’s finances. Currently, acceptance of the protection plan, that is the arrangements made with the person to prevent future harm, is a rather crude measure of outcome. 46% of people accepted their protection plan arrangements, which is low. Some of this is due to lack of mental capacity but also it must represent a significant number who have capacity and choose to remain in circumstances we would consider risky. Changes in the annual returns for 2013-14 will have more focus on outcomes with a new requirement to determine if SA action has lead to risk reduction or not. Also, there will be a category to indicate where a SA investigation ceased at the request of the individual concerned.

<u>Comparison with other Local Authorities</u>

The Health and Social Care Information Centre publish a report for LB Hillingdon, comparing our performance with other Local Authorities with a similar profile (our “comparator group”) and comparing with safeguarding performance with the figures for England. The comparator report for 2012-13 has not been finalised in time for use in the annual report so reporting is restricted to comments on emerging themes from the report.

- Alerts and referrals for LB Hillingdon are higher than our comparator group indicating a good level of awareness of safeguarding adults in the community.

- Repeat referrals as a percentage of all referrals are lower than our comparator group indicating safeguarding concerns are resolved first time.
- Despite an increase in safeguarding activity, there are a higher number of completed referrals as a percentage of all referrals than our comparator group indicating partners are reaching a resolution of the safeguarding concern.
- Referrals from the public are higher than our comparator group indicating good community awareness of safeguarding adults at risk
- The percentage of abuse falling within the "inconclusive / not determined" category is lower than our comparator group indicating better decision making and recording processes.

There are indications of improvement needed in ensuring basic information on primary client group and ethnicity is recorded and up to date. Also, acceptance of protection plans to ensure future protection of the person abused is lower than our comparator group. This data will change for 2013-14 to allow recording of acceptance by a carer or other person if the victim of abuse lacks capacity to accept the plan themselves. It is anticipated the figures will then improve.

Mental Capacity Act and Deprivation of Liberty

Responsibility now rests with 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.

The number of applications for a deprivation of liberty remains low for the period April 2012 to date. In all there have been 9 requests for a standard authorisation, 5 cases from Hospital and 4 cases from Care Homes. In 4 of the Hospital cases they were not granted, the circumstances not meeting the statutory criteria. The one case where it was granted related to a person who was placed on the mental health unit where deprivation of liberty safeguards were deemed the more appropriate route rather than detention under the Mental Health Act.

In relation to Care Homes, 3 requests were not granted as either the best interests assessment criteria were not met and alternative, less restrictive options could be used or, the circumstances did not amount to a deprivation of liberty but a reasonable and lawful restriction. Of the 2 granted, in both cases representation for the person was arranged.

LB Hillingdon has robust monitoring of registered Care Homes and the Inspection staff are well aware of circumstances that could be seen as a deprivation. Care Homes and Hospitals are the settings where deprivation of liberty safeguards apply. Therefore we are reasonably confident there are not circumstances where people are being unlawfully deprived of their liberty. However, as part of the learning from WBV (see paragraph 13 above) there is a focus on ensuring reviews consider if the circumstances of care could be considered a deprivation of a person's liberty. All adult social care staff have

received additional training in this area, funded through the specific mental capacity grant money.

The NHS SAAF indicated amber for mental capacity assessments and deprivation of liberty applications. It was felt that staff, generally, were un confident in this area, and this was confirmed by case review. Of particular difficulty are cases where capacity seems to vary and fluctuate over time. Recommendations from the case review have been incorporated into our action plan for 2013-14

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 2012/13 the team made 97 visits to registered care home where LB Hillingdon has placed people. 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. Recent joint action involving the police, CQC, our inspection team and the safeguarding adult team concerned a domiciliary care agency and resulted in a prosecution.

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. For the year 2012-13 69.7% of eligible service users were in receipt of a personal budget. 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. 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. In response, sessions were set up for all front line staff to receive training in mental capacity and to be aware of potential deprivation of liberty circumstances. Work has also taken place across partners in this area e.g. Hillingdon Hospital Trust have strengthened their protocol.
- Use of cases, case audits and case examples to inform and improve practice. Adult Social Care have introduced a quality assurance framework that includes case file audits which is now embedded in normal supervisory practice and can be collated to identify strengths and weaknesses in practice.
- A need to improve partnership working and information exchange –with Police, CPS, care providers. This is being addressed through the development of the Multi-Agency Safeguarding Hub (MASH) which enables better sharing of intelligence about safeguarding both children and adults at risk.
- The need to be able to use inspection and monitoring of care providers to drive up standards. The LB Hillingdon Inspection team works closely with the safeguarding adults' service and has developed a risk matrix that collates concerns about care providers, thus enabling them to focus their inspections on particular areas where providers are not meeting proper standards of care. In the future the client data system will also support this work through enabling recording and reporting of safeguarding concerns about organisations providing care.
- Better support services, particularly in respect of mental health and support for carers. There have been recent developments to improve

advocacy services with the re-tendering of the service and greater focus on outreach support to adults at risk living in the community.

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

Effectiveness of the SAPB

The peer review framework for safeguarding adults at risk, as used by the LGA, has been adopted by the SAPB as its outcome framework. This will mean the Board, through the performance and policy sub group, reviewing each of the themes within the framework to measure and improve LB Hillingdon's performance in safeguarding. Two themes have already been reviewed; outcomes and people's experiences of the safeguarding process and a paper on this was presented to the June 2013 Board. Subject to confirmation of the Board, there are areas that need strengthening, for example how we link with the wider community safety agenda involving the anti-social behaviour team, trading standards and domestic violence. Also, what work is undertaken with perpetrators, where this is appropriate, to change their behaviour.

The SAB independent chairs have developed a quality assurance tool for SABs and this will be considered and adapted for the Hillingdon SAPB in consultation with Board members.

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. Performance figures overall indicate high levels of awareness and robust response to safeguarding concerns

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. In this context the SAPB has developed further local guidance and procedures to ensure robustness of response to concerns.

Hillingdon is compliant with the initial review requirements from the Winterbourne Review and the SAPB is developing ways to monitor progress against the recommendations contained in the Francis Report.

We are well placed to comply with any requirements arising from the Care Bill and are looking to further develop our work in 2013-14 to use information from

risk assessments to assess the effectiveness of the safeguarding response to concerns.

6. NATIONAL AND LOCAL CONTEXT: implications for safeguarding

Government policy

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 coalition Government refreshed these principles with a further statement on the 10th of May 2013 which drew on safeguarding national events since 2011. It placed the following emphasis on local safeguarding activity

- Collaborative working to improve outcomes and avoidance of duplication
- Providers’ core responsibilities to ensure safe, effective and high quality services
- Work collectively to respond appropriately to safeguarding concerns as well as those concerns that relate more to service standards.
- Ensure commissioned services are of a high quality and arrangements are robust for responding to concerns.

The statement retained the principles outlined above but wanted more emphasis on prevention and proportionate response to concerns.

The Care Bill

The Government has accepted the recommendation of the Law Commission in making SAPBs statutory. The Care Bill being progressed through

Parliament outlines proposed changes for safeguarding adults. These included:

- 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 which may broaden those adults considered at risk.
- The functions of the SAPB will be defined in statute.
- Section 47 of the National Assistance Act 1948 will be repealed as incompatible with the European Convention on Human Rights.

Depending on the statutory scope of the SAPB's work and requirements placed on the Local Authority, there will be 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 has enabled efficient use of existing resources. Despite this, it is noted that administrative gaps do emerge with the need, for example, to take forward the work of the Winterbourne View Hospital review outcomes

NHS changes

The NHS continues to evolve and by the end of 2012-13 the local cluster groups were replaced by GP led Clinical Commissioning Groups (CCGs) . In Clinical Commissioning Groups (CCGs) taking over their responsibilities, there was an assurance process required of them by the NHS Commissioning Board which includes reference in several parts to safeguarding, both children and adults. E.g. "Clear line of accountability for safeguarding is reflected in CCG governance arrangements" and the CCG "has arrangements in place to co-operate with the local authority in the operation of the LSCB and SAB." The respective Boards worked with the CCGs on the assurance process which has been completed and usefully defines the expectations on our new Health partners. A related change also occurred in April 2013 when the former Hillingdon PCT handed over their Supervisory Body functions under the Mental Capacity Act / Deprivation of Liberty Safeguards to the Local Authority. LB Hillingdon was in the fortunate position of operating a joint Supervisory Body with the PCT prior to this transfer and there was no significant impact. A small Central Government grant to facilitate this change meant there are also no financial implications.

Winterbourne View and the Francis Report

The scandal of Winterbourne View (WBV) Hospital has been prominent with the conviction of the perpetrators of abuse at this private Hospital for people with learning disabilities and autism, run by Castlebeck. The convictions in

August 2012 enabled the release of the Serious Case Review (SCR) by Gloucester Social Services and on the 10th of December 2012, the publication of the Government's report into Winterbourne View. The SAPB has already been briefed on the recommendations arising and reviewed the ADASS compendium of recommendations which draws together the number of reports published on WBV.

LB Hillingdon and partners' response to WBV has been to set up a sub-group of the SAPB, linked in to the Learning Disabilities Partnership Board and reporting to both Boards. An Action Plan, based on the Department of Health's final report recommendations and the LGA "stock take" of WBV actions, issued recently, has been drafted and was discussed at the SAPB in June 2013. LB Hillingdon and partners are compliant in meeting the immediate and critical deadline of June 2013 for reviewing all Learning Disability service users placed in assessment and treatment facilities commissioned by Health.

The SAPB are also looking at the outcomes from the Francis Report into the neglect of patients at the Mid-Staffordshire Hospital, with a presentation by the Hillingdon Hospital Trust at the joint LSCB and SAPB slot in June.

Local developments

The London multi-agency safeguarding adults at risk policies and procedures are now implemented in all London Boroughs underpinned by practitioner's guidance. The policy and procedures introduces a consistent framework by which adults are safeguarded. It means having consistent definitions of roles and responsibilities, timescales for responding and promotes better partnership working and in particular, cross boundary working. There have been no financial implications for LB Hillingdon. These policies and procedures are being reviewed across London, in the light of some partner changes e.g. Health, and there will be some minor amendments to the procedures. There are no planned major changes in the way safeguarding adults operate across London until the final outcome of the Care Bill. As indicated earlier in this report some reconfiguring of the adult care pathways

Will take place in 2013-14 to improve multi agency working and reduce duplication

Multi-Agency Safeguarding Hub [MASH]

The MASH model is a national multi-agency initiative to provide information sharing arrangements across all agencies involved in safeguarding children. Those involved are employed by their respective agency i.e. police, health and local authority and located in one office.

Hillingdon have signed up to developing the MASH model at the point of referral within Children's Social Care. Hillingdon have further committed to managing Adult Safeguarding referrals using the MASH model. In doing so they would be one of the first London Borough to achieve this duel role.

A MASH Operational Delivery Group has been set up and taken responsibility to deliver Hillingdon's MASH by end of September 2013. The group includes representatives of all the key agencies involved in safeguarding

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

Performance activity, local and national learning, plus consultations with staff and partners, has indicated that our priorities are the right ones. We have reframed these for 2013-14 in line with the ADASS standards for safeguarding and performance. They are detailed below with our planned activities identified under each one.

There is a challenging work programme for 2013-14 but the Board wishes to give particular priority to obtaining users views and outcomes of interventions, and in supporting staff to work with people of varying and uncertain capacity

Priorities 1,2: Outcomes, People's experiences of safeguarding

- Ensure decisions are person led
- Ensure outcomes are assessed and measured

Priorities 3,4,5: Leadership Strategy and Commissioning

- Oversee implementation of recommendations from the Winterbourne Report and CQC review of learning disability services
- Oversee implementation of recommendations of the Francis report

Priority 6: Service Delivery and Effective practice

- Continue to ensure that policies and procedures are embedded in practice
- Improve awareness and response to abuse and exploitation by financial means
- Increase staff awareness of issues of self neglect/hoarding and how to respond
- Improve response to allegations of financial abuse
- Develop better ways of assessing risk across partner agencies
- Develop better identification and support of vulnerable adults through MASH
- Ensure effectiveness of staff training and recruitment processes

Priority 7: Performance and resource management

- Develop and disseminate local guidance regarding mental capacity and Deprivation of Liberty

Priority 8: Local Safeguarding Board

- Ensure effective working relationships with new Health agencies and the Health and Wellbeing Board
- Improve effectiveness of the SAPB quality assurance processes
- Implement learning from case reviews
- Ensure SAPB meets the requirements of Government regulation and guidance

Individual agency plans

Age UK

Key Plans for 2013-14

- Keep up to date with new developments in Safeguarding and Disclosure and Barring.
- Add information on safeguarding adults to our website.

Hillingdon Carers

A continued focus on safeguarding will be reflected in:

Carers Conference 2013 – a key note presentation will cover issues arising from mental capacity, Power of Attorney, confidentiality and consent. (The Carers Conference is an annual event organised by Hillingdon Carers in partnership with three voluntary sector and two statutory organisations);

Carers Fair 2013 in Mall Pavilions Shopping Centre Uxbridge will involve over 40 organisations and provide an opportunity for promotion and highlighting of safeguarding messages by statutory and voluntary sector partners within a community event.

Young Carers Plus – a new service for young carers of parent or parents with mental ill health in the south of the borough will provide new opportunities to identify and support families where there is a risk that safeguarding could become an issue.

The Hillingdon Hospital

To increase awareness and confidence for staff in using the MCA by increased training and the use of Trust MCA forms. Re-audit on the application of the MCA and understanding and care of Learning Disability patients will take place. There will be implementation of a Vulnerable Adults section divider to be placed in the patients medical notes. The Safeguarding Adults policy will be reviewed in addition to the SAAF review.

Brompton and Harefield

Identify key plans for 2013-14:

- To continue to deliver safeguarding leadership, training and guidance to strengthen processes and procedures in line with government and local guidance including the Prevent Strategy.
- To develop specific guidance to govern the use of restriction and restraint.
- To improve current work with regards to patient, users and carers involvement with regards to safeguarding.
- To learn from serious case reviews.

CNWL HCH Proposed Developments

HCH has chosen to reflect the 6 safeguarding adults priorities as has SAPB as its objectives, with a target attached to each one.

- Priority 1 – Empowerment: Staff development remains a priority, focus on key issues of safeguarding.
- Priority 2 – Protection: To ensure that all national drivers and new documents for safeguarding adults' are considered and if appropriate reflected into practice or learning for HCH staff.
- Priority 2 – Protection: To raise the profile of Prevent and aid staff to recognise patients who may be at risk of being targeted to be involved in the systematic use of violence and intimidation to achieve political ends.
- Priority 3 - Prevention: To target the gaps in clinical staffs' knowledge regarding caring for a person with a learning disability. This will be done by providing targeted training on the subjects identified in the Learning Disabilities audit.
- Priority 3 – Prevention: To lead on at least two meaningful audits. There will be a re-audit of RiO care plans for people with LD and an audit of clinical staff's safeguarding adults awareness including the referral process, to ensure that the training given is clear and memorable.
- Priority 4 - Proportionality: To ensure that all staff have an opportunity to increase their knowledge about MCA and DoLS, by offering good training and continuing with offering case studies and discussion with individual teams and by attending service leads' meetings.
- Priority 5 – Partnership: To continue and build on the work regarding carers. This is a Quality Priority for HCH during 2012/13
- Priority 6 – Accountability: To keep policies up to date, to ensure that they reflect current documents and legislation.

CNWL mental health services

- The "think family" agenda is a huge issue for adult services and one where there is much to learn from CAMHS colleagues. There are impacts of hidden harm that the services need to identify consistently. To address this, the Trust has established a project in Spring 2013 to promote "think family" as part of service delivery in service lines.
- Mental health services are moving to payment by results as its major funding source from 2014/15. This means 2013/14 will be a shadow year for these changes. The Trust is carefully monitoring the impact of changing service delivery into service lines and would welcome partner agencies views on any unforeseen impacts.
- CAMHS, like other service lines, have plans to complete service redesign/ improvement work. This will include developing groups across the service with children, young people and their carers and other stakeholders to test out our ideas on service planning and redesign.
- The Trust will be looking to tender the software packages used and it is hoped that this will allow the opportunity to resolve some of these data issues.

- CNWL may apply for Children and Young People IAPT, which embeds a CBT model of service delivery with extensive outcome evaluations using a range of measures. Other Boroughs are currently doing the training and the learning may be rolled out to Hillingdon staff in the next year.

London Fire Brigade

For 2013-14 we will endeavour to carry out in the region of 2500 further Home Fire Safety Visits, again targeting the most vulnerable.

We are also attempting to visit all Local Authority Sheltered Housing schemes within the Borough to give fire safety input to the residents.

APPENDIX 1: SAPB membership

Chairman Lynda Crellin -Independent

Local Authority

- Cllr Phillip Corthorne – Cabinet Member (SCH&H) LBH
- Merlin Joseph – Deputy Director (SCH&H) LBH
- Nick Ellender – Service Manager, Safeguarding Adults at Risk LBH
- Karen Wardlaw – Human Resources LBH
- Paul Hewitt – Service Manager, Safeguarding Children LBH
- Marcia Eldridge – Learning & Development Manager (SCH&H) LBH

Health

- Barbara North – Safeguarding Adults Lead, Hillingdon Community Health
- Maria O'Brien – Managing Director, Provider Services, Hillingdon PCT
- 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 Reva Gudi – CCG GP Lead
- Ceri Jacob – CCG Executive Lead
- Esme Young – CCG Management Lead

Police

- Graham Hamilton – Detective Inspector, Public Protection Group, 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 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,

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.)

6. Winterbourne View Hospital Recommendations

This is a time limited sub-group, formed with a remit to review the outcomes and recommendations arising from the Department of Health review of Winterbourne View Hospital and other relevant reports, and to frame a local multi-agency response. It is chaired by the Service Manager for Disabilities LB Hillingdon.

Remit.

a) To review the contents, outcomes and recommendations of the following documents and any other relevant information the sub-group deems appropriate.

- "Transforming care: A national response to Winterbourne View Hospital" (Department of Health final report – December 2012)
- "DH Winterbourne View Review Concordat: Programme for Action" (December 2012)
- "Winterbourne View – A Compendium of Key Findings, Recommendations and Actions" (ADASS)

b) To formulate a multi-agency Hillingdon response to the recommendations identified in the documents in a) above, write an action plan of key tasks to be completed, with timescales, (bearing in mind Government requirements) and to recommend which Hillingdon individuals or agencies should be responsible for the key tasks. To also prioritise these key tasks and identify and include any actions already taken that relate to recommendations in the documents above.

c) To identify any actions required that fall outside the remit of partner agencies within Hillingdon or other 'gaps' and to recommend what actions be taken, at what level, with regard to these.

d) To identify to the Safeguarding Adults Partnership Board Chair and Learning disabilities Partnership Board Chair any significant areas of risks ahead of presenting the completed action plan with recommended actions.

c) To present the completed action plan to the Safeguarding Adults Partnership Board and Learning Disabilities Partnership Board for approval by 29th June 2013 (SAPB) and 9th of July 2013 (LDPB)

d) To recommend what monitoring arrangements should be in place for ensuring the action plan is completed and how this monitoring is maintained after completion.

e) To recommend what future commissioning arrangements should be for services, to ensure they are in line with the model of service delivery in the action plan