Hillingdon Safer Adults Partnership Board Annual Report 2013 - 14

Contents

1. INTRODUCTION

This report covers the work of the Hillingdon Safer Adults Partnership Board (SAPB) during 2013-14. It highlights the main achievements in safeguarding Hillingdon's vulnerable adults and identifies the priority areas for improvement for the following year and beyond.

Statistical and performance information covers the period April 2013-March 2014 with significant developments in the early part of 2014-15 also included.

Ensuring strong safeguarding for adults relies on strong commitment and collaboration across services. This is evident through 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.

During this year we improved quality control mechanisms by:

- Establishing a Vulnerable Person's Panel that acts as a forum for professional discussion of self-neglect cases (such as hoarding) that are a cause for concern. The panel agrees strategies for each case working across agencies.

- Creating a Care Governance Board within the Council's Adults Services to oversee the quality of local provision and coordinate action where services fall below quality thresholds.

The Care Act 2014 will require the establishment of an Adults' Safeguarding Board by April 2015. The Board will be required to have an annual plan and an Annual Report. The Act requires agencies to co-operate to deliver Safeguarding requirements. In addition, the draft guidance advises local areas to consider pooling funding to support the work of the Board.

As we move towards statutory Adult Safeguarding Boards we now hold the Adults' Board on a different day to the Children's Board.

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

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

The Making Safeguarding Personal agenda is the thread running through the Care Act implementation. This will present a challenge to all. A recent court judgement has greatly increased the workload in respect of Deprivation of Liberty assessments, and while a review of this is planned, it will not report until 2017. The current increase has added a significant amount of pressure to Council services.

The actions arising from the Winterbourne Review are still ongoing and the challenge remains to ensure the safeguarding of those in long term care while planning their move into community settings.

We need to develop capacity and improved quality assurance mechanisms in the SAPB to enable us to assess the quality of our interventions on the ground.

The personalisation agenda is extremely positive but means that we must help people assure themselves of the quality of care they are purchasing.

Lynda Crellin

Independent Chairman

January 2015

2. WHAT WE HAVE DONE

What we planned to do – our key priorities

WHAT WE SAID WE WOULD DO	WHAT WE DID
Outcomes, peoples experience of safeguarding	
Ensure that decisions are person led through informed consent whenever possible.	Acceptance of protection arrangements increased by 21%. Low level of complaints.
Leadership, strategy and commissioning	
Implement the recommendations from the Winterbourne Report and Care Qualities Commission Review of learning disability services.	Sub groups were set up to oversee establishment of local action plan, reported at each SAPB meeting. All actions on target. Those currently in placements were reviewed and SAPB assured of their safeguarding arrangements. In 2014 we have jointly commissioned with Hillingdon Clinical Commissioning Group a review of Learning Disability Services to inform our future plans for Learning Disability Services. This will inform how local services are reshaped in the light of the Winterbourne report and will be reported on in the 2014/15 Annual Report.
Implement recommendations from Francis Report.	Hospital Trusts gave assurances about compliance and outstanding actions to SAPB in October 2014.

WHAT WE SAID WE WOULD DO	WHAT WE DID
Service delivery and effective practice	
Continue to ensure pan London policies and procedures are embedded in practice.	Procedures used across all agencies. No problems reported in feedback. Review planned but deferred until implementation of Care Act.
Improve our awareness and response to abuse or exploitation originating via electronic means.	The new Homecare contract will include a requirement to ensure that all providers have a call monitoring system in place. The impact of this will be reported upon in the 2014/15 Annual Report.
Ensure and improve response to allegations of financial abuse	Some actions have been agreed as part of Safeguarding response to referrals. As the Board takes on a statutory role in April 2015 further work will be undertaken with the Safer Hillingdon Partnership.
Develop better ways of assessing risk across partner agencies.	Risk assessment now forms part of the data set that comes to SAPB.
Staff development and training to remain a priority and to focus on identified issues.	The e-learning module is in place and in use. Each agency carries out training and reports on this to SAPB. Further training on investigations undertaken for social care staff following reorganisation.
Amend recruitment policy and guidance to comply with revised CRB guidance and the Protection of Freedoms Act.	Completed within each agency.

WHAT WE SAID WE WOULD DO	WHAT WE DID
Develop better identification and support through Multi Agency Safeguarding Arrangements (MASH).	The MASH live date had been postponed at time of writing but there will be a senior social worker in Adults who will link with the MASH in the first few months. This will ensure good links between the MASH and Adults Safeguarding. It is proposed to review this in year to determine if closer alignment is required.
Performance and resource management	
Increase staff awareness of issues of self neglect/hoarding and how to respond.	Protocol and procedure developed and agreed. Plans for hoarding panel evolved into Vulnerable Persons Panel which considers all complex cases of vulnerable people through multi agency discussion and agreed actions.
Develop and disseminate local guidance around Deprivation of Liberty.	Meeting held with providers Forum. Training undertaken for providers in 2014. Web information has been reviewed as part of social care information to the public.
Develop greater professional responsibility and awareness ('whistle blowing') on poor practice and safeguarding adults at risk.	Care Governance Board established to monitor quality of care.
Safeguarding Adults Board	
Seek representation of Clinical Commissioning Group and GPs as providers on the SAPB.	CCG represented by manager and GP representatives. Lead GP for safeguarding appointed.

WHAT WE SAID WE WOULD DO	WHAT WE DID
Improve effectiveness of SAPB quality assurance processes.	Joint SAPB/NHS SAAF (Self Assessment Assurance Framework) agreed via London chairs group and implemented early 2014. Followed up by local challenge session confirm safeguarding arrangements within each agency and agree joint priorities for 2014-15.
Learn from case reviews.	Action plan from case review 2013 completed. New Serious Case Review action plan agreed in 2014.
Ensure SAPB meets requirements of Government guidance and regulation.	Postponed until spring 2015 to await Govt regulations and guidance. Review of SAPB to be completed ready for Care Act implementation. Protocol agreed with Health and Wellbeing Board.

Main Adult Safeguarding Achievements 2013-14

Hillingdon Council

A Vulnerable Persons [Hoarding] Panel now meets on a monthly basis. The Panel is a multi-agency forum chaired by the London Fire Brigade that shares information and best practice ideas with regard to complex cases including `self-neglect` and hoarding.

Care Governance arrangements have been strengthened with a regular monthly meeting chaired by the Council's Director of Adult Social Care. The meeting brings together the Safeguarding Adults Lead, Inspection and Monitoring, Performance and Category Management professionals.

The Safeguarding Adults service was reorganised in early 2014. The specialist Safeguarding team was disbanded and resources moved into Locality teams.

The Authority is now in a stronger position to work pro-actively with all service users to ensure their health and well-being are safeguarded, with changes

effectively making "Safeguarding Everybody's Business". Quality audits are planned for 2015 to ensure that the quality of safeguarding investigations is maintained, and that any findings feed into ongoing workforce development.

Hillingdon Hospital

The Head of Safeguarding received a Trust CARES award in recognition of her work for and with people with learning disabilities within the reporting period.

Central North West London NHS Trust (CNWL)

- The development of local Learning Disability Champions. This has shown commitment by individuals who have attended local learning events and have championed awareness-raising and improvement via their local service meetings.
- The ability to identify and record “carers” on our electronic patient record system so that proactive support can be put in place for those individuals.
- The opportunity to attend and present cases to the multi-agency Vulnerable Persons Panel.
- Safeguarding Adults mandatory training is consistently well attended, with an average compliance rate of 98%.
- Prevent health WRAP (workshop to raise awareness of Prevent) training is consistently offered to teams. The figures are sent to the Department of Health monthly to ensure compliance.
- Records and statistics of all safeguarding adults cases worked on are kept, with outcomes which enable the safeguarding adult’s team to monitor local themes and trends, and helps support organisational learning.
- Safeguarding leads identified in each mental health team.
- Every Datix incident report is looked at and checked to ensure that there are no possible safeguarding adult issues.
- Safeguarding adults team led on 3 audits in 2013/14. One of these audits was regarding the safeguarding adults mandatory training. In 2012/13 the audit was to ensure that the training was thorough. This had a very positive result and showed that overall the training was well received by staff. In 2013/14 this audit was built on further, by taking a random sample of staff and asking them questions about what they remembered about the training received. Again the results were good, but showed that there was some required to guarantee that all staff were aware of who the lead agency is, however all staff audited knew who to contact within CNWL with safeguarding adult queries.
- Training has been provided to Child and Families (C&F) staff with regard to mental health and addictions. Addictions and adult mental health community teams have a reciprocal arrangement where link workers from C&F meet with teams to discuss cases.

Royal Brompton and Harefield Trust

The Trust's Adult Safeguarding Policy has been revised and updated to include:

- A revised Prevent (Preventing Violent Extremism) flow chart
- Supervision for staff assessing and escalating safeguarding cases
- Deprivation of Liberty guidance
- Female Genital Mutilation (FGM)

- Prevent Strategy - Trust Executives with Safeguarding responsibilities met local Prevent police liaison officers and NHS England London Prevent to improve understanding of the Prevent and Channel referral process. The Safeguarding adult policy has been updated with a more comprehensive Prevent flow chart.

- Safeguarding/pressure ulcer protocol - The Trust is working with the Tri-borough safeguarding adult board to develop a pressure ulcer protocol to ensure there is agreement about when a pressure ulcer incident should be escalated to a strategy meeting.

- Safeguarding training standards - The Trust is working with the Tri-borough SAPB Developing Best Practice sub-group to develop a minimum standard for each of the safeguarding training levels and for MCA and DOL awareness. The objective is to develop minimum standards for partners to aspire to and produce training material for use in training sessions.

Age UK Hillingdon

420 volunteers and staff work for Age UK Hillingdon to support older people with the organisation and each volunteer is trained on safeguarding adults as part of their induction.

Age UK reviews its policies and procedures on a regular basis to ensure compliance with safeguarding and raises awareness of safeguarding with all staff and volunteers so that there is a clear process for reporting abuse.

DASH

DASH has in place robust policies for safeguarding, safer recruitment and whistle-blowing. All policies form part of our induction process and safeguarding is discussed regularly in team meetings and supervision. Staff are encouraged to raise any concerns with their team leader or the Chief Officer.

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

All staff and volunteers are DBS checked. Casual volunteers (e.g. from Uxbridge College) at sports sessions are not checked as they are constantly supervised.

People employing Personal Assistants are assisted to follow safer recruitment procedures and DBS check the people they choose to employ.

We continue to encourage the people we work with to expect high standards from people who are working with them.

Participants at our activities are encouraged to report hate crime and with the help of an advocate and the local police we have had some successful outcomes.

Police

The Multi Agency Safeguarding Hub (MASH) now based at the Civic Centre has replaced the previous Public Protection Desks. They carry out similar functions but have more key stakeholders in the partnership than previous allowing for greater sharing of information and resources, therefore greater risk management and improved safeguarding. More statistics are provided in Appendix 3.

London Fire Brigade (LFB)

LFB initiated a local management review into the support provided to a vulnerable adult who sadly died in a fire at home, which resulted in recommendations for some partners to improve specific aspects of their service provision.

Fire crews in Hillingdon delivered 2518 free home fire safety visits to Hillingdon residents, of which 83% were to vulnerable people. In addition, a number of arson letter-boxes were fitted and sets of fire retardant bedding were provided to vulnerable residents at high risk from fire.

A major initiative during 2013-14 was the creation of a Hoarding Panel made up of key partners to review high-risk cases involving people who hoard materials in their homes. This initiative was adopted by the Safeguarding Adults Board to become the Borough's Vulnerable People Panel, chaired by the LFB. The panel receives referrals from agencies and organisations who deal with vulnerable people that fall outside of adult safeguarding criteria. Typically, the individuals represent those who suffer from self neglect due to lifestyles or health issues.

Further information on partner agencies' adult safeguarding work is provided in Appendix 3.

3. GOVERNANCE AND ACCOUNTABILITY

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 consists of all the main statutory agencies and voluntary groups who contribute to the safeguarding of vulnerable adults. A full list of members can be found in Appendix 1.

The membership and terms of reference of the Board will be reviewed and updated during 2014 in line with the Care Act 2014.

Independent chairman

Since November 2011 the SAPB has had an independent chairman, who also chairs the Local Safeguarding Children's Board (LSCB).

Relationship to agency boards

There are links across to the Safer Hillingdon Partnership and Older People's Assembly . Safeguarding also links to the Multi Agency Public Protection Arrangements (MAPPA) and the Multi Agency Risk Assessment Conference (MARAC). The Annual Report will be presented to Council Cabinet, Health and

Wellbeing Board and the Safer Hillingdon Partnership. In the spirit of partnership work in Hillingdon, each agency represented on the SAPB has contributed to this report.

The Board asked all partners to provide details of their governance arrangements, contributions to safeguarding, and training activity. Information is provided in Appendices 3 and 4.

Actions planned within each agency are included in section 7, What We Need to Do.

Sub groups

Most activities relating to the SAPB business plan have been led by a Service Manager, supported by the sub groups. These were 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 in Appendix 2.

4. LEARNING FROM CASE REVIEWS AND AUDITS

Serious Case Review (SCR)

The Board commenced a Serious Case Review in year, which was all but finished. This concerned a person who died in hospital but had clearly experienced neglect at the hands of her carer during the months immediately preceding her death. Although the review is still ongoing at the time of writing this report, some actions have already been put in place concerning procedures applying in case of non-contact (community health) and procedure for responding to alerts raised by London Ambulance Service.

Case Review

The Board also completed one further case review in summer 2013, using the SCR methodology. This 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.

The action plan associated with this case has been completed. The embedding of awareness and practice about assessment of capacity remains a key priority for the Board going into 2014.

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.

Performance information

In April 2013, the Abuse of Vulnerable Adults return (AVA) was deleted by the Health and Social Care Information Centre (HSCIC) and the Safeguarding Adults return (SAR) was introduced. The following provide some of the main measures from the SAR return; further information and comparator data can be found in Appendix 3.

In 2013/14, Hillingdon Council:-

- Opened 499 safeguarding referrals. Of these:
    - 319 (64%) were from females, comparable to the national (60%) and regional (57%) returns.
    - 160 (32%) came from residents aged over 85.
    - 50 (10%) were previously unknown to adult social care.
    - 305 (61%) were from residents with a physical disability, above the national (51%) and regional (52%) returns.
- Closed 590 referrals, of these:-
    - 175 (30%) were due to an allegation of neglect or an act of omission, comparable to the national (30%) and regional returns (30%).
    - 250 (49%) were alleged to have taken place in the clients own home, above the national (42%) return and slightly below the regional (51%) return.
    - 290 (57%) were closed and resulted in no further safeguarding actions, above the national (36%) and regional (36%) returns.
    - 205 (40%) were closed and the risk was removed (20%) or reduced (20%), below the national (22%;35%) and regional (25%;33%) returns.

- 170 (32%) cases were substantiated fully, in line with the regional (32%) and national (30%) returns.
- 170 (32%) cases were not substantiated, comparable with the national (30%) and regional (34%) returns.
- 115 (22%) residents lacked the capacity, below the national (28%) and regional (32%) returns, however there were a greater number of clients that it was not recorded if they had capacity (33%). This will be rectified to ensure that all cases have the persons capacity recorded.

Mental Capacity Act and Deprivation of Liberty (DoL)

Responsibility now rests with the Local Authority as the sole Supervisory Body.

There are currently 2 Best Interests Assessors and the work of the Supervisory Body is overseen by the Safeguarding and Quality Manager, with support from a Senior Practitioner and Administrative Officer.

The number of applications for a DoL remains low for the period April 2013 to date. In all there have been 15 requests for a standard assessment, all from Care Homes. All were granted, and therefore were considered appropriate and proportionate

LBH 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. As part of the learning from Winterbourne Review (WBV) however, 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 Supreme Court judgements in the "...P v Cheshire West and Chester Council..." and "...P and Q v Surrey County Council..." in March 2014, are very significant in determining whether care/treatment arrangements for an individual lacking capacity amount to a DoL.

The Court determined that there are two key questions to consider in determining whether a person is deprived of their liberty:

- Is the person subject to continuous supervision and control?
- Is the person free to leave?

If the answer to both questions is no then the person is deprived of their liberty. Factors that are deemed no longer relevant are:

- The person's compliance or lack of objection

- The relative normality of their placement
- The reason or purpose of a particular placement

Implications for Hillingdon

This judgement has lead to a very significant increase in numbers of requests for both standard and urgent authorisations during 2014. This will place pressure on the current capacity of trained Best Interest Assessors.

In 2013/14 LBH received 15 requests for authorisations. Since the judgement 19th March 2014, LBH has received over 150 applications for the first half of the year. We have estimated that over 500 assessments may need to be undertaken for people placed by LBH. In addition there will be requirements to undertake assessments for an unknown number of people in hospital or placed by the CCG who are eligible for NHS continuing care.

We are in the process of disseminating information to Managing Authorities and partners to help them identify when applications are required. There will be a need to revisit some previous decisions made prior to the judgement.

Applications to the Court of Protection will be required for people in settings outside residential care homes and hospitals whose care is in part or wholly public funded e.g. supported housing.

Authorisation reviews are required on an annual basis so the anticipated increased demand will be on-going.

It would not be possible for the existing trained staff to undertake the number of assessments likely to be required. We are in discussion with other London boroughs and ADASS nationally is involved in assessing the impact of these changes. Locally we have set up a mini project board to oversee this task which we have invited representatives from the CCG and Hillingdon Hospital. The plan is to:

- Inform providers of the changes and outline the things they need to put in place to ensure least restrictive options are considered.
- Second the two members of staff who are trained as Best Interest Assessors (BIA) into the Safeguarding and Quality Team and back fill their posts .
- Train up an additional 6 assessors from existing staff.
- Contract with an external agency/ independent individuals to provide BIA assessments.
- Increase administrative support to two full time members of staff.
- Risk assess applications and prioritise accordingly.

The recent changes in case law will result in a considerable increase in the numbers of people who require a DoL authorisation. This will require considerable additional financial resources.

Outcomes of audits and Inspections

The safeguarding adults at risk service works closely with their colleagues in the inspection team of LBH. The role of this team is to monitor the service provision and quality of care of those providers contracted to the LBH. 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 LBH senior management team and contract monitoring meetings are held with the service providers themselves. During 2013/14 the social care inspection team carried out 155 inspections of domiciliary care services, residential and nursing homes, supported living and sheltered housing service. In addition the team worked with the police who led on the investigation of the activities of a domiciliary care agency who provided services to Hillingdon residents.

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 LBH.

The team has a particularly important role 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, LBH inspection team and the safeguarding adult team concerned a domiciliary care agency and resulted in a prosecution.

Personalisation

Personalisation focused 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 also 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 2013-14 2,790 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 Self Directed Support referrals being made to the safeguarding team.

Effectiveness of the SAPB

The London Safeguarding Adults Board (SAB) independent chairs have developed a quality assurance tool for SABs in association with NHS England (London Region). The resulting tool replaced the NHS SAAF and was completed by Board partners in spring 2014. Results were collated at a challenge day in June 2014.

All agencies had robust policies and procedures in place and an appropriate focus on adult safeguarding. There was considerable consensus about the challenges and areas for development which have been incorporated into the SAPB plan for 2014-15.

Membership and terms of reference of the Board will need to be refreshed to meet the requirements of the Care Act and to ensure maximum effectiveness.

Overall effectiveness

The information we have given provides reassurance that the multi-agency system to safeguard adults in Hillingdon is working well. There is strong multi agency commitment through the SAPB, evidenced by the information provided in this report. Safeguarding 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 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 all those currently in a hospital setting have had their care reviewed. Plans are in place to move those from hospital settings into the community, though this has considerable resource implications as the existing funding remains with NHS England and does not revert to the placing authority. The Winterbourne sub group is being reviewed to ensure more focus on commissioning and to look at what care and support needs to be put in place for users.

The SAPB is developing ways to monitor progress against the recommendations contained in the Francis Report. LBH and SAPB are well placed to comply with any requirements arising from the Care Act and are looking to further develop our work in 2014/15 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 Department of Health made clear that the "No Secrets" statutory guidance would remain in place until at least 2013. The principles within the statement were building on this guidance, reflecting what had come out of the national consultation process. They made clear that the Government's role was to provide the vision and direction on safeguarding, ensuring the legal framework, including powers and duties, is clear and proportionate, whilst allowing local flexibility. Safeguarding is seen as everyone's business encouraging local autonomy and leadership in moving to a less risk adverse way of working, focusing more on outcomes instead of compliance.

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

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

The Government 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 Act 2014

The Government has accepted the recommendation of the Law Commission in making SAPBs statutory. The Care Act outlines changes for safeguarding adults. These include:

- 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 LBH 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, LBH'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 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. 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 prior to the recent court judgement.

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 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.

LBH 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 is reported on at every SAPB meeting. LBH and partners were compliant in meeting the deadline of June 2013 for reviewing all Learning Disability service users placed in assessment and treatment facilities commissioned by Health.

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 introduce 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 LBH.

Procedures will need to be updated by April 2015 to meet the requirements of the Care Act.

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.

LBH have signed up to developing the MASH model at the point of referral within Children's Social Care. LBH 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 dual role.

A MASH Operational Delivery Group was 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 2014 onwards

The SAPB held a challenge day with partners in Spring 2014 in order to review the quality audit and agree SAPB priorities for the future.

There was a great deal of consensus about the challenges faced and priorities required. Headline priorities agreed were:

- Ensure SAPB is reviewed and refreshed in line with the Care Act.
- Improve staff awareness about the Mental Capacity Act and its use, and ensure this is embedded in practice.
- Improve practice through use of staff supervision and consultation (including exit interviews) across agencies.
- Improve the information available to help improve performance information and information about quality of care.
- Improve information about outcomes for service users, and improve satisfaction levels.

Performance activity, local and national learning, plus consultations with staff and partners, has indicated that our priorities are the right ones.

Outcomes for Service Users

Improve information about service user outcomes and increase satisfaction ratings:

- Continue to use risk assessments to demonstrate risk reduction.
- Increase service user involvement in care planning, using advocates as appropriate.

Leadership strategy and Commissioning

- Implement the recommendations from the Winterbourne Report and Care Qualities Commission Review of learning disability services.
- Successfully implement recommendations and requirements from Francis report.

Service Delivery and Effective Practice

- Develop better identification and support through Multi Agency Safeguarding Arrangements (MASH).
- Improve awareness and response to abuse or exploitation originating via electronic means.
- Ensure and improve response to allegations of financial abuse.

Performance and Resource Management

Develop and improve SAPB performance monitoring systems:

- Establish dashboard of multi agency data, to include DoL applications.
- Assess quality of local practice by receipt of reports from Governance Board, Vulnerable Persons Panel, Sudden Untoward incidents (SUIs).
- Develop programme of themed Multi Agency Case Audits (MCA).

Ensure an effective workforce:

- Deliver multi agency training/workshops on MCA.
- Each agency to improve use of supervision and other methods (e.g exit interviews) for consulting with staff and embedding good practice.
- Carry out staff survey.

Effectiveness of SAPB

Ensure compliance with Care Act:

- Review and update terms of reference and membership.
- Secure agreement for resources from partner agencies.
- Consolidate and establish multi agency sub groups.
- Revise and update procedures.
- Consolidate relationships with other strategic groups.

Learn from case reviews:

- Audit practice relating to 2012-13 case review.
- Complete SCR and develop action plan.

Individual agency plans

Hillingdon Council

Key plans include:

- Building in robust quality assurance arrangements around Safeguarding and general Social work practice.
- Developing outcome focussed, person centred planning, within the context of Safeguarding adults.
- Embedding awareness and consideration of Deprivation of Liberty issues in everyday Social work practice.
- Continue to develop Care Governance Board.
- Implement workforce development programme.
- Join the Making Safeguarding Personal Initiative.

Age UK

- Keep up to date with new developments in Safeguarding and Disclosure and Barring.
- Develop existing database to include alerts and keys steps taken in relation to safeguarding for individuals.

- Implement the Care Act Safeguarding measures as required.

The Hillingdon Hospital

Key challenges include:

- The achievement of > 80% compliance with Level 1 Safeguarding Adult training.
- A greater understanding and embedding of MCA and DoLS for staff, especially in the light of recent developments with DoLS, though improvement can be evidenced by the yearly re-audit findings.

Brompton and Harefield

Key plans and priority actions include:

- To continue to deliver safeguarding training in line with Government guidance.
- To develop a minimum standard for each of the safeguarding training levels and for Mental Capacity Act (MCA) and Deprivation of Liberty (DOL) awareness in conjunction with local SAPBs.
- Develop areas highlighted by the safeguarding audit tool in conjunction with local SAPBs.
- Continue to develop the Prevent awareness roll out across the Trust.
- Target the non-clinical non-patient facing staff of the Trust who are the majority of the staff who have not received any Safeguarding training.
- Ensure the Trust meets all requirements of the Care Act.

CNWL

Key plans include:

- The Care Act provides a legislative duty on all organisations to protect and support people who need it most and to take forward elements of the government's initial response to the Francis Inquiry. This is likely to require changes to how safeguarding is managed across the organisation.
- New legislation regarding DoLs will have a direct impact on how front line staff manage cases and training will need to be changed to incorporate this.
- It is acknowledged that staff struggle to apply the theory of MCA and DoLs to clinical practice and therefore the content of training will be further evolved to place a much greater emphasis on 'case studies' to embed learning in practice.
- To secure more places on WRAP Training for CNWL key staff in order to deliver more Prevent training to staff.
- To identify and target teams that do not ring with safeguarding adults queries and do not raise safeguarding adults alerts, to ensure that staff in these teams have sound understanding of the safeguarding adults process in Hillingdon.
- To be involved in training for children's services about where the Children and Families Act meets MCA.

- To build and maintain open contacts with the local voluntary organisations where change has taken place.
- To work with LBH to look at agreeing the best model for the Safeguarding Adults Manager (SAM) resource within the integrated health and social community mental health teams.
- To work with LBH to develop staff as SAMs in order to be more involved in investigations.
- To embed the use of Datix system to assist senior management in triangulation of information with regards to safeguarding, incidents, complaints etc. to identify any areas of concern. To provide training to staff to support this approach.
- To develop tracker system across the borough's mental health services to capture all the safeguarding processes and analyse the number of alerts, referrals and type of abuse.
- To ensure process is more user-led and record what a user wants as the outcome of an alert and investigation being carried out.
- Domestic Violence training to be sourced and offered to all staff.
- Structures for Safeguarding Adults across the trust to be reviewed and to consider the establishment of a local CNWL Hillingdon safeguarding group which brings together both our community and mental health services.
- To lead on 3 meaningful audits these are planned to be staff opinion of MCA training received, whether staff are completing care plans for patients with learning disabilities properly and recognising the reasonable adjustments needed and thirdly auditing what services clinical staff are directing carers too.
- To continue to take part in any SAPB multi agency work, including attendance at SAPB sub-groups when they are re-introduced.
- Review of Trust information-sharing policy within multi-agency framework and develop process and system to support frontline staff to share information.
- To carry out across the trust a user-led audit, Oct/Nov 2014 with the Trust NICE clinical lead to test whether the safeguarding process has helped at risk adults feel safer.
- CNWL Safeguarding Adults review to take place by an external safeguarding adult's specialist.

London Fire Brigade

Key plans include:

- To continue to promote the use of sprinklers and other automatic fire suppression systems in buildings used to house vulnerable people, or to have them discreetly installed temporarily in the homes of vulnerable people to assist them to remain living in their home.

- To focus attention on care homes and sheltered housing in the Borough. 2400 free Home Fire Safety Visits (HSFV) (1920 in the Borough) will be delivered of which 80% will be in the homes of vulnerable people. Existing HFSV partnerships with organisations that provide services to vulnerable people will be maintained and a number of other partnerships

will be established to ensure that 20% of our HFSV referrals come from our partners.

- The LFB will continue to work with the LBH to tackle the Beds in Sheds phenomenon and ensure that Houses of Multiple Occupation (HMO) are fire safe for those that reside in them.

8. CONCLUSIONS

The information we have indicates that we are successfully supporting residents and safeguarding vulnerable adults**.** Response and investigation has on the whole been speedy and proportionate and vulnerable adults have been appropriately safeguarded. The establishment of the Care Governance Board and the Vulnerable Persons Panel have created constructive vehicles that should enhance multi agency communication and information sharing.

Case reviews and other information, however, also indicate that there are some potential risk areas. Staff remain unconfident in use of the Mental Capacity Act and there is evidence of further improvement needed in information sharing, particularly at high risk transition points such as admission to and discharge from hospital. We need to ensure that reorganisation in social care does not lead to a reduction in assessment and planning standards.

Reductions in resources across all agencies inevitably has an impact on capacity and external factors – such as High Court Judgement on DoL – puts increased strain on those resources.

Whilst partnership working is strong, we have concerns about commissioning processes, particularly the separation of responsibilities across the Clinical Commissioning Group and NHS England. This has an impact on planning, particularly for those who are mentally ill, or who have learning disabilities. NHS England has so far not been represented on the SAPB, although we understand that there are plans to develop co-commissioning arrangements. We also wish to develop our relationships with GPs as critical providers and coordinators of services.

The implementation of the Care Act along with the personalisation agenda, will involve a step change in how all professionals work with adults.

LBH have commissioned a review into the SAPB to assist us in our planning for Care Act implementation, to ensure we can be as effective as possible in our monitoring and assurance role.

It is vital that all partners ensure that the SAPB is appropriately resourced to carry out its functions and to comply with its statutory responsibilities.

APPENDIX 1: SAPB membership

Chairman Lynda Crellin -Independent

Local Authority

- Cllr Phillip Corthorne – Cabinet Member LBH
- Tony Zaman - Director of Adult Services, Adult Social Care & Interim Director of Children & Young People's Services LBH
- John Higgins – Head of Safeguarding Quality and Partnerships LBH
- Marcia Eldridge – Learning & Development Manager LBH
- Sharon Daye - Interim Director Public Health LBH

Health

- Barbara North – Dignity &Safeguarding Adults Lead, Hillingdon Community Health
- Maria O'Brien – Divisional Director of Operations, CNWL Trust
- Anna Fernandez – Safeguarding Lead, Hillingdon Hospital Foundation Trust
- Sandra Brookes – Service Director, Adult Mental Health Services, CNWL
- Helen Goodman - ICP Project Manager/Discharge Improvement Lead Royal Brompton & Harefield Hospital Trust
- Dr Reva Gudi –GP Lead CCG
- Esme Young –Management Lead CCG

Police

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

Voluntary Sector

- Angela Wegener – Chief Executive, DASH
- Karen Elliott, Age UK Hillingdon
- Christopher Geake, MIND
- Claire Thomas/Julie Simmonds – Hillingdon Carers
- Graham Hawkes - Healthwatch Hillingdon

Other

- Jerome Kumedzina, London Fire Brigade

APPENDIX 2: 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.
(d) 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.
(e) To undertake the work, with partners, to implement the action plan agreed by the SAPB.
(f) 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.

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.

(e) 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).

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

(g) 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.

APPENDIX 3: Governance and partnership adult safeguarding activity

HILLINGDON COUNCIL

Adult Social Care conducts investigations for safeguarding referrals of vulnerable adults. This was undertaken by a central team but from March 2014 this function has been devolved into operational teams. This is consistent with our approach that safeguarding is everybody's business.

The Department has run a number of training courses on both conducting safeguarding investigations and carrying out the safeguarding adult's manager role. This has now become an ongoing programme.

The Department has established a Care Governance Board and provider risk panel to further enhance the over view of quality in local services. The board is over seen by the Director of Adult Services and ensures that a strategic approach is taken to developing the quality of local services.

The activity information related to Adult Safeguarding is reported elsewhere in this report. The performance team produce monthly reports about safeguarding referrals. The performance reports are regularly reported to the Senior Management Team and the Safeguarding Adults Partnership Board.

POLICE

Missing Persons Unit

The Missing Person's Unit is a dedicated unit with experienced staff whose primary function is to manage the investigations of Adults reported as missing. Their aim is to locate missing persons, make them safe and ensure a full de-brief is held upon their return.

To provide some insight into the volume of investigations dealt with by the unit we can confirm that between the 1st April 2013 and to 31.March 2014 there were **456 adults** reported as missing in Hillingdon Borough. These are broken down into the following categories. Missing persons are graded differently in terms of risk, this enables senior officers to decide the level of response each investigation receives.

- 275 were male
- 181 female.
- 71 High Risk (36 Male/35 Female)
- 245 Medium Risk (149 Male/96 Female)
- 140 Low Risk (90 Male/50 Female)

MASH (Multi Agency Safeguarding Hubs)

The Multi Agency Safeguarding Hub (MASH) now based at the Civic Centre has replaced the previous Public Protection Desks. They carry out similar functions but have more key stakeholders in the partnership than previous allowing for greater sharing of information and resources, therefore greater risk management and improved safeguarding. Again Statistics below demonstrates the volume of work done by the unit:

5894 Pre Assessment Checklists/Pre birth were received, 1,486 more than the previous year.

MONTH	Children	Adult
April 2013	399 PACS	+44 Adult PACS
May 2013	438	+30
June2013	389	+60
July 2013	428	+50
Aug 2013	316	+63
Sept2013	388	+63
Oct 2013	440	+107
Nov 2013	395	+105
Dec2013	400	+108
Jan 2014	426	+99
Feb 2014	385	+120
March 2014	480	+161

Its worthy of note that the figures show a significant increase in Pac's for Vulnerable Adults and this trend has continued into this financial year.

April 2014	489	+147 Adults
May 2014	498	+171
June 2014	480	+169
July 2014	535	+154
Aug 2014	420	+185

The Hillingdon MASH team also deals with Heathrow policing commands PACS as they do not have their own MASH.
Unfortunately within Merlin separation of these figures cannot be achieved to ascertain the percentage of reports that are generated from the airport because all reports default to Hillingdon borough because of Heathrow's geographical location being on Hillingdon boroughs area.

Whilst the MASH has been set up and is in place it awaits a "go live date". It is working well and will be enhanced further when additional resources from key partners are committed to the project. This will ensure effectiveness and deliver quality outcomes.

MAPPA (Multi-Agency Public Protection Arrangements)

The MAPPA is responsible for the risk assessment, management and planning for cases under the following criteria:

Category 1: All registered sex offenders.

Category 2: All violent offenders sentenced to a custodial sentence of 12 months or more for a violent offence listed under schedule 15 of the Criminal Justice Act 2003; subject to a section 37 Hospital Order for a violent offence; any sex offenders who are not registered.

Category 3: Any offender with an eligible previous conviction (violent of sexual offence) who presents a high risk of serious harm to the public and the case requires multi-agency risk management.

This year Hillingdon MAPPA have received on average 12 referrals per month, under the three categories above.

The cases are managed at 3 levels:

Level 1: Single agency management;

Level 2: Active multi-agency management;

Level 3: 'The Critical Few', requiring management by senior staff with the authority to commit extra resources to managing the risk.

There have been three cases managed at level 3 for a number of months during 2013/14, involving senior members of staff and involving complex issues of both child protection and the risk management of child offenders. To put into context the resource intensity required of these cases there were 11 meetings, 6 alone for one case.

VOLUNTARY SECTOR

Voluntary Sector agencies are critical to the work of the Safeguarding Adults Partnership Board 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.

Hillingdon Carers

Internal governance arrangements:

A comprehensive internal review in 2012-13 conducted in response to changes in Disclosure and Barring Service requirements resulted in the following changes:

- Safer recruitment arrangements.
- On-going checks are carried out for volunteers.
- Measures to ensure our practice reflects current legal frameworks through a review of roles and responsibilities.

In addition, we continue to:

- Include safeguarding issues in supervision sessions for every member of staff.
- Access regular training for all staff/volunteers that have regular contact with children and/or vulnerable adults.
- Use safeguarding prompts on all assessment documentation/checklists.
- Maintain centralised records of all safeguarding issues.

Raising awareness:

Hillingdon Carers has continued to raise awareness of the importance of safeguarding by:

- Prompting the general public to report abuse and access support services through our webpages: www.hillingdoncarers.org.uk
- 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.

HEALTH AGENCIES

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 2013/14. 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 reported to the Trust's Safeguarding Committee, which reports to the Quality and Risk Committee on a quarterly basis.

The Trust has a multi-agency Safeguarding Committee, which meets on a quarterly basis and covers both adults and children safeguarding work. The Committee is chaired by the Executive Director of the Patient Experience and Nursing.

The safeguarding adult audit (SAPB audit) was completed by the Trust, with a multi-agency validation event held in June 2014.

The Learning Disability assurance framework and the revised Key Performance Indicator for Learning Disability were also approved by the Safeguarding Committee. 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, with an overview of clinical incidents presented at each Safeguarding Committee.

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

Contribution to improving safeguarding during 2013-2014

In order to provide assurance that the Trust is listening and responding to the needs of patients with a Learning Disability, the Head of Safeguarding attends a variety of forums where there are carers and service users. This is an excellent opportunity to hear the views of people and to respond to their questions.

The Trust is represented at the Learning Disability Partnership Board by the Head of Safeguarding, who is also a member of the multi-agency Serious Case Review panel. Within the reporting period there was one case review and an

ongoing SCR .There has been learning from the case review in terms of the use and application of the Mental Capacity Act (MCA).

In 2013/14, there was re-audit of staff knowledge and awareness of the 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. The results showed an improvement on the previous audit.

An audit was conducted on Learning Disability awareness and vulnerable patients, focussing on how the Trust staffs looks after these patients whilst in hospital. The results were positive; staff knew who to contact if there were concerns. Their needs however to be increased awareness and use of the 'patient passport'.

Training compliance for the reporting period is below the required compliance of 80% Safeguarding Adults awareness training is delivered monthly as part of the Statutory and Mandatory staff training programme and it is also part of the New Starters Induction programme to the Trust. Safeguarding Adult awareness training is now also available via e-learning, accessed via ESR. Bespoke sessions are provided within departments as requested.
There are planned non-mandatory bespoke sessions for MCA .

The safeguarding adults' policy has been revised and approved by the Trust.

Royal Brompton & Harefield NHS Foundation Trust

Governance arrangements in respect of adult safeguarding

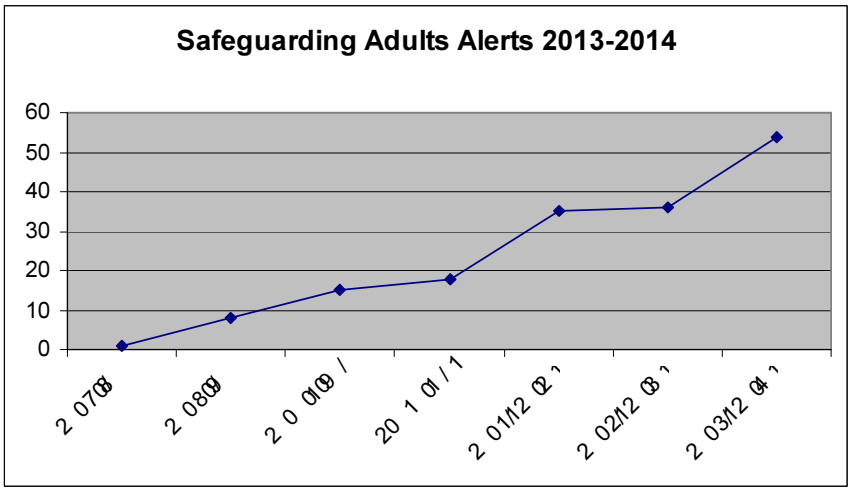
The Director of Nursing and Clinical Governance is the Director responsible for Safeguarding, reports to the Trust Board and Chairs the Mental Health and Safeguarding Board.

An Annual Report is produced to inform the Trust Board on issues relating to Safeguarding.

The Datix incident /complaints and claims reporting mechanism is used to record and investigate all safeguarding incidents. Complaints can be taken directly to the safeguarding lead of the Mental Health and Safeguarding Board.

Referrals

Chart 1 - RBHT Number of Safeguarding Adults at Risk Alerts (2013/2014)



This chart shows the significant progress made by the Trust on raising the profile of safeguarding adults at risk over the past few years.

Central and North West London NHS Trust (CNWL)

Internal Governance

The Board of Directors receive regular updates on safeguarding adults issues and serious incidents are reported and discussed in detail at the Trust Board confidential session. The Board also receives annual training on adult safeguarding as part of the presentation of the Annual Report.

Since April 2013 the quarterly Trust Wide Safeguarding Group, a sub-committee of the Board, has been chaired by the Director of Nursing and Quality, who is the Executive Director lead for Safeguarding across the Trust.

Membership consists of the Trust Named Doctors and Nurses, the Trust Safeguarding lead, Associate Director of Operations, key management and operational leads from mental health services, community and addictions. In addition, appropriate leads, for example, from Human Resources, are in attendance.

Hillingdon Community Services (CNWL) has a Safeguarding Group which reports to the Trust-wide Safeguarding Group summarising all the key adult safeguarding issues including the audit programme, training compliance, safeguarding incidents, progress in delivery of the annual work plan, any identified risks and measures being taken to mitigate risks. There are professional links between the safeguarding adult lead Nurse and the Trust Safeguarding Adult lead.

Each CNWL mental health service line has an identified safeguarding lead who reports direct to their Service Director. The safeguarding lead reports directly into the Trust-wide safeguarding Group. The lead social worker in CNWL Hillingdon mental health services acts as the main link with the safeguarding team at Hillingdon Council. All data relating to safeguarding alerts from our mental health services is collated by this post holder. Our mental health safeguarding alert data is submitted to the joint section 75 monthly meeting and, within the Trust, is discussed in detail in the relevant service line Quality and Performance meetings.

The Trust takes a full and active role in working with the various SAPBs in the boroughs where the Trust provides services. In Hillingdon, the Divisional Director of Operations, (vice-chair of the SAPB), the Borough Director for mental health services and the Hillingdon Adult Safeguarding Lead represent CNWL on the SAPB.

Feedback from SAPB meetings is cascaded to relevant Service Lines/Directors, and disseminated through Borough Interface Meetings and the relevant Care Quality and Performance Groups, as well as at the Trust Safeguarding Group Meetings. Local SAPB priorities are also incorporated into the relevant Trust work plans.

Local Governance

CNWL has a commitment and a duty to safeguard vulnerable adults as stipulated in Outcome 7 of the Care Quality Commission Regulations. To achieve this goal the organisation has to ensure robust systems and policies are in place and are followed consistently. Each service submits evidence via the internal on-line reporting system to evidence compliance as part of our internal assurance process. Audit is key for improving service performance, each service is expected to lead and be involved in annual audits; these results are reviewed at local governance meetings and, where indicated, improvement plans put in place.

CNWL's safeguarding adult's policies and procedures have been revised to reflect *'Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse'* (SCIE 2011). Safeguarding adults training has been adjusted to incorporate these procedures to ensure all staff are aware of and are working within London multi-agency policy and procedures.

The Datix incident report system now allows Serious Incidents, adult safeguarding and complaints to be more easily identified to ensure wider organisational learning.

London Fire Brigade (LFB)

The LFB's governance for Adult Safeguarding is a combination of central and local management arrangements. Adult and Child Safeguarding policies provide guidance to fire crews regarding neglect and abuse and detail the reporting processes and timescales. Fire crews report any safeguarding issue to a Duty Deputy Assistance Commissioner (DAC), who liaises with Social Services and the Borough Commander. A record is kept of the safeguarding referral to Social Services. Both senior officers are responsible for ensuring the safeguarding issues are resolved satisfactorily. The Borough Commander will track interventions made by other agencies and ensure that LFB interventions are completed. The DAC will follow-up with the Borough Commander to ensure the matter has been dealt with and may be recorded as closed.

During 2013-14 LFB made 11 safeguarding referrals, of which 9 related to adults.

APPENDIX 4: WORKFORCE

In 2014 the Council changed the Adult Social Care operating model for managing safeguarding cases. Previously responsibility lay with a single team. Following reorganisation safeguarding became a responsibility for all teams. Expertise within the central team was preserved by moving staff into operational teams.

In the initial phase specialist workers continued to undertake safeguarding investigations while other team members took comprehensive training.

Under Phase two safeguarding work can be allocated to any member of the operational teams, with the Safeguarding Adult Manager (SAM) role carried out by team managers.

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. 307 social care staff have completed this module and 229 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 adults whilst maximising their choice and independence. Training for front-line staff was completed by 195 staff over seven sessions and 23 managers were provided with training to promote good practice in capacity assessments.

Training activity across agencies

Hillingdon Council

Basic Safeguarding Children training was available to all Adult Social Care staff as an e-learning module. This training was offered to staff and external partners.

The Hillingdon Hospitals NHS Foundation Trust

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 Psychiatric Liaison Consultants based at Riverside.

The Trust training recording structure has been replaced by a system called WIRED, which will improve the accuracy of recording staff compliance, which also links into the Electronic Staff record (ESR).There remains a challenge in order to reach 80% compliance with Safeguarding Adult awareness training at level 1.

Royal Brompton and Harefield

The figures below show training for the period 1/4/13 to 31/3/14	
769 people (up from 684 – 12/13) received SGA training of which;	
523 - Level 1	Induction
174 - Level 1	Classroom
42 – Level 1	E-learning
30 – Level 2	Classroom
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
Compliance percentage for SGA at year end was 54% done in date, 16% done but out of date (70% have attended training at some point)	

Trust attendance at SGA training by staff group

CNWL

Education is a key component in raising awareness about Adult Abuse. This training is mandatory and is well attended, there is always good feedback. Staff from any CNWL division can attend the training. The training matrix is as below:

Training Level	Summary of Course	Audience	Trainer
Investigators Training	This is a higher level course aimed at staff who may be asked to take a part in safeguarding adults' investigations.	Managers involved in investigation and safeguarding adults team	Social Services
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	CNWL Hillingdon's Safeguarding Adults Team
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	CNWL Hillingdon's Safeguarding Adults Team or E-Learning or workbook

MCA & DoLs training is also offered, as well as Prevent, these are well attended.

Age UK

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

- Safeguarding Adults – e-learning
- Safeguarding Vulnerable Adults Workshop
- Safer Recruitment

Hillingdon Carers

All staff receive initial safeguarding training and a refresher every other year.

All volunteers are offered training, and it is mandatory for volunteers with children and vulnerable adults.

London Fire Brigade

All the Borough's fire crews received training on the safeguarding policies in 2013-14 and will do so again in 2014-15, however, opportunities for additional training in relation to specific lifestyles that lead to adults being exposed to a higher risk from fire will be explored during 2014-15.