Annual Report 2014 – 2015

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

City and Hackney Safeguarding Adults Board

CITY OF LONDON

Hackney

City & Hackney Older People's Reference Group

DOMINE DIRIGE NOS
CITY OF LONDON

NHS
City and Hackney
Clinical Commissioning Group

East London NHS
NHS Foundation Trust

Homerton University Hospital NHS
NHS Foundation Trust

LFB
LONDON FIRE BRIGADE

METROPOLITAN POLICE
Working together for a safer London

VoiceAbility

Hackney

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1 Foreword by the Chair of the Safeguarding Adults Board

This was a significant year in the history of adult safeguarding, as the City and Hackney Safeguarding Adults Board prepared for the Care Act 2014 to come into force on 1st April 2015. The importance of adult safeguarding, and of the partnership working that underpins it, is recognised in the Act. Safeguarding Adults Boards are the bodies that test out the effectiveness of that partnership working and the past year has been one where the City and Hackney Board has done that in a number of ways.

The London Borough of Hackney and the City of London have diverse, vibrant communities, with many organisations and individuals not only doing effective adult safeguarding, but also committed to the Safeguarding Adults Board and the partnership it represents. These factors mean that being chair of the Safeguarding Adults Board is a real privilege and a pleasure, and I have had that privilege over the last two years.

In 2014/15, I set out with the Board to achieve two major things during the year – these were: firstly to further develop the way we work together as a board and to try and reach a point where we were always curious about partnership work in adult safeguarding, and asked enough questions of each other around the Board; and secondly to create a partnership budget and set up a small team to support the Board, which had previously been supported by some dedicated individuals from the local authority as part of many other adult safeguarding responsibilities held by that team. In both these areas we made huge strides. The partnership budget was agreed for the future of the Board, and the Board's support team is being established. That City and Hackney have achieved this is testimony to the importance that the organisations here give to adult safeguarding.

There is considerable work still to do, which will need the consistent commitment of all the organisations on the Safeguarding Adults Board – this report gives an indication of what the challenges are in the City of London and in Hackney, but also I hope, a sense of the quality of the work that is done to safeguard adults. Dr Adi Cooper has taken over as Board chair (from June 2015) and I am full of optimism about where the Board can go with her leadership. Thank you all for your support. I would like to wish everyone well, and also to recognise the work of the adult safeguarding team at London Borough of Hackney, who in addition to their main role, have provided the administration and support to the Board as it has developed over several years.

Fran Pearson
Independent Chair

2 Introduction

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations in City and Hackney working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted. This includes having regard to the person's views, wishes, feelings and beliefs in deciding on any action. This annual report describes arrangements for safeguarding adults at risk of abuse and neglect in the City of London and London Borough of Hackney. It describes key developments in local multi-agency adult safeguarding systems in 2014/15, along with a statistical analysis of the casework activity, and reports from those individual agencies, who are members of the Safeguarding Adults Board.

The Care Act 2014

As noted in the Foreword, the Care Act (2014) was implemented in April 2015. It represents the most significant reform of care and support in more than 60 years and its importance to adult safeguarding cannot be over-stated.

The Care Act outlines a general duty for local authorities to consider the physical, mental and emotional wellbeing of people needing care and support, with an emphasis on taking steps to prevent, reduce or delay needs for care and support for all local people, including adults and carers. The Care Act states that protection from abuse and neglect is central to the concept of a person's wellbeing. It sets out a clear statutory framework for how local authorities and other key partners, such as care providers, health services, housing providers and criminal justice agencies, should work together to protect an adult's right to live in safety, free from abuse and neglect. It introduces new safeguarding duties for local authorities including: leading a multi-agency local adult safeguarding system; making or causing enquiries to be made where there is a safeguarding concern; carrying out Safeguarding Adults Reviews; arranging for the provision of independent advocates; and hosting Safeguarding Adults Boards.

Under the Care Act an adult at risk of abuse or neglect is considered to be someone, aged 18 years or over, who:

- has needs for care and support (whether or not the local authority is meeting any of those needs), and
- is experiencing, or at risk of, abuse or neglect, and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

In considering what constitutes abuse or neglect, the Care Act removes the previous threshold of "significant harm", no longer requires there to be "an alleged perpetrator" and sets out a broad understanding of what can constitute abuse or neglect in adult safeguarding. This can be:

- physical abuse
- sexual abuse
- financial or material abuse
- discriminatory abuse
- neglect and acts omission
- domestic violence
- psychological abuse
- modern slavery
- organisational abuse
- self-neglect

The Care Act sets out the requirements for the establishment and functioning of Safeguarding Adults Boards, which have three core, statutory duties. They must:

- develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute
- publish an annual report detailing how effective their work has been
- commission Safeguarding Adults Reviews (SARs) for any cases which meet the SAR criteria

All adult safeguarding work in City and Hackney will now be based on the six key principles contained in the Care Act and the Board will use these to examine and improve our local arrangements:

- **Empowerment** – People being supported and encouraged to make their own decisions and give informed consent

- **Prevention** – It is better to take action before harm occurs

- **Proportionality** – The least intrusive response appropriate to the risk presented

- **Protection** – Support and representation for those in greatest need

- **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

- **Accountability** – Accountability and transparency in delivering safeguarding.

3 The City & Hackney Safeguarding Adults Board

3.1 WHO WE ARE

The City and Hackney Safeguarding Adults Board (the Board) is a multi-agency partnership of statutory and non-statutory stakeholders, including the Metropolitan Police, East London Foundation Trust, London Fire Brigade and the Homerton NHS Foundation Trust (see Appendix 1). The core membership of the Board already includes all agencies required by the Care Act. The Board met at least three times a year, and had an Independent Chair, Dr Fran Pearson. A new Independent Chair, Dr Adi Cooper started in June 2015.

The Board seeks to bring about positive outcomes for adults who live within the area of the City of London and the London Borough of Hackney, or who live outside the boroughs as a result of a placement made by the City of London, Hackney Council, or the East London Foundation Trust.

3.2 WHAT WE DO

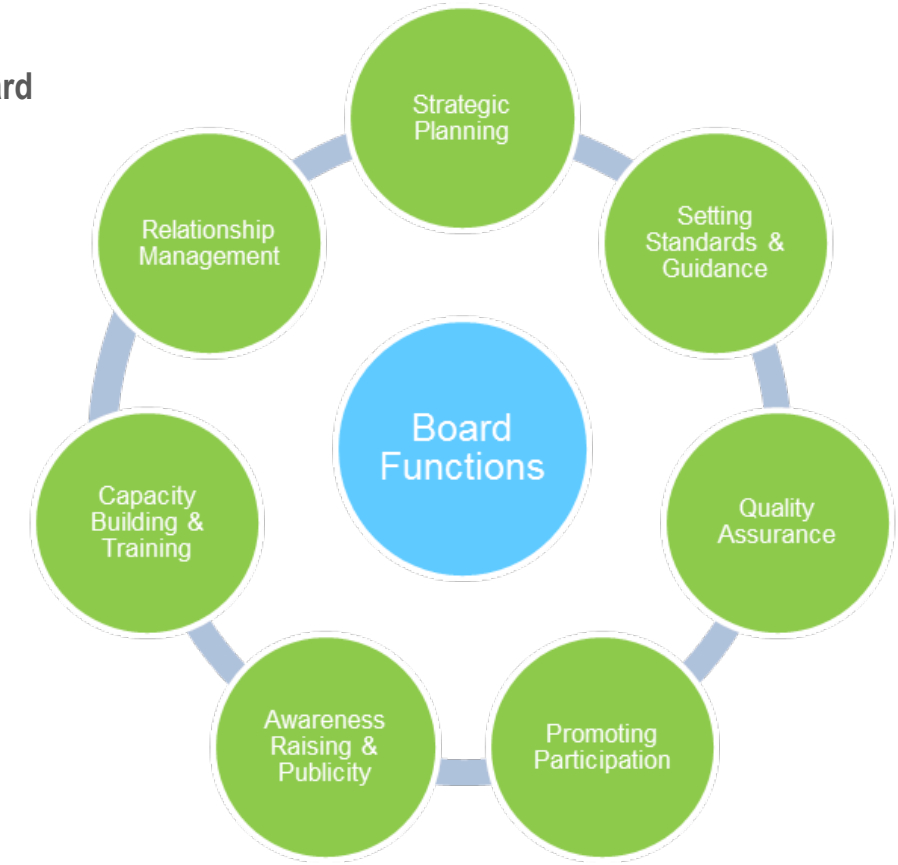
The overarching purpose of the Board is to assure itself that effective local safeguarding arrangements are in place and work collaboratively to prevent abuse and neglect where possible. It is the role of the Board is to develop, lead and co-ordinate the local strategy to safeguard adults at risk of harm or abuse in City and Hackney. The Board is committed to:

- preventing adult abuse and neglect happening in the community and service settings
- promoting the safeguarding interests of adults at risk to enable their wellbeing and safety
- responding effectively and consistently to instances of abuse and neglect
- learning together

The Board has a focus on preventing abuse as well as a robust response to incidents of abuse. Strong strategic links with other key partners are essential and the Board co-ordinates the activities of each agency represented on the Board for the purpose of safeguarding adults in the City and Hackney. It also ensures the effectiveness of what is done by each person or agency in contributing to safeguarding adults in the area.

The Board is responsible for ensuring that the safeguarding agenda focuses on adults who experiencing or at risk of abuse or neglect staying in as much control of the decision making as possible, whilst taking reasonable measures to ensure that risks of harm are minimised.

Functions of the Board



3.3 OUR KEY PRINCIPLES

Four key principles underpin the Board's strategic plan (as agreed by the Board in February 2015):

- All our learning will be shared learning
- We will promote a fair and open culture
- The skill-base of our frontline staff and managers will be improving continuously; and
- We will understand the local complexity of safeguarding

3.4 OUR GOVERNANCE ARRANGEMENTS

To support the delivery of the Board's work programme an executive board was established in 2014, chaired by the independent chair of the Board. The executive board includes senior managers of key agencies. It has developed the Board's five year strategy and it oversees implementation of the annual strategic plan. Members of the executive board chair the subgroups and provide regular updates. The five year strategy 2015-2020 describes the governance framework, including subgroups and task and finish groups, which are set up to deliver the Board's overarching strategy and vision. The five subgroups are:

- Safeguarding Adults Review (SAR)
- City of London
- Quality Assurance
- Training and Development
- Communications and Engagement

Functions of these groups include: prevention; applying lessons learned from incidents through our training programme; increasing public awareness; promoting the health and wellbeing of our residents; with the overall aim of increasing independence and ensuring that proportionate action is taken to safeguard our vulnerable residents.

The SAR subgroup started functioning during 2014/15 (see SAR summary, section 7). The other subgroups were in the process of being set up during this period.

3.5 OUR STRATEGIC LINKS

The Board continued to develop its relationships with other strategic bodies as described in the Care Act guidance. The Board has formal links with:

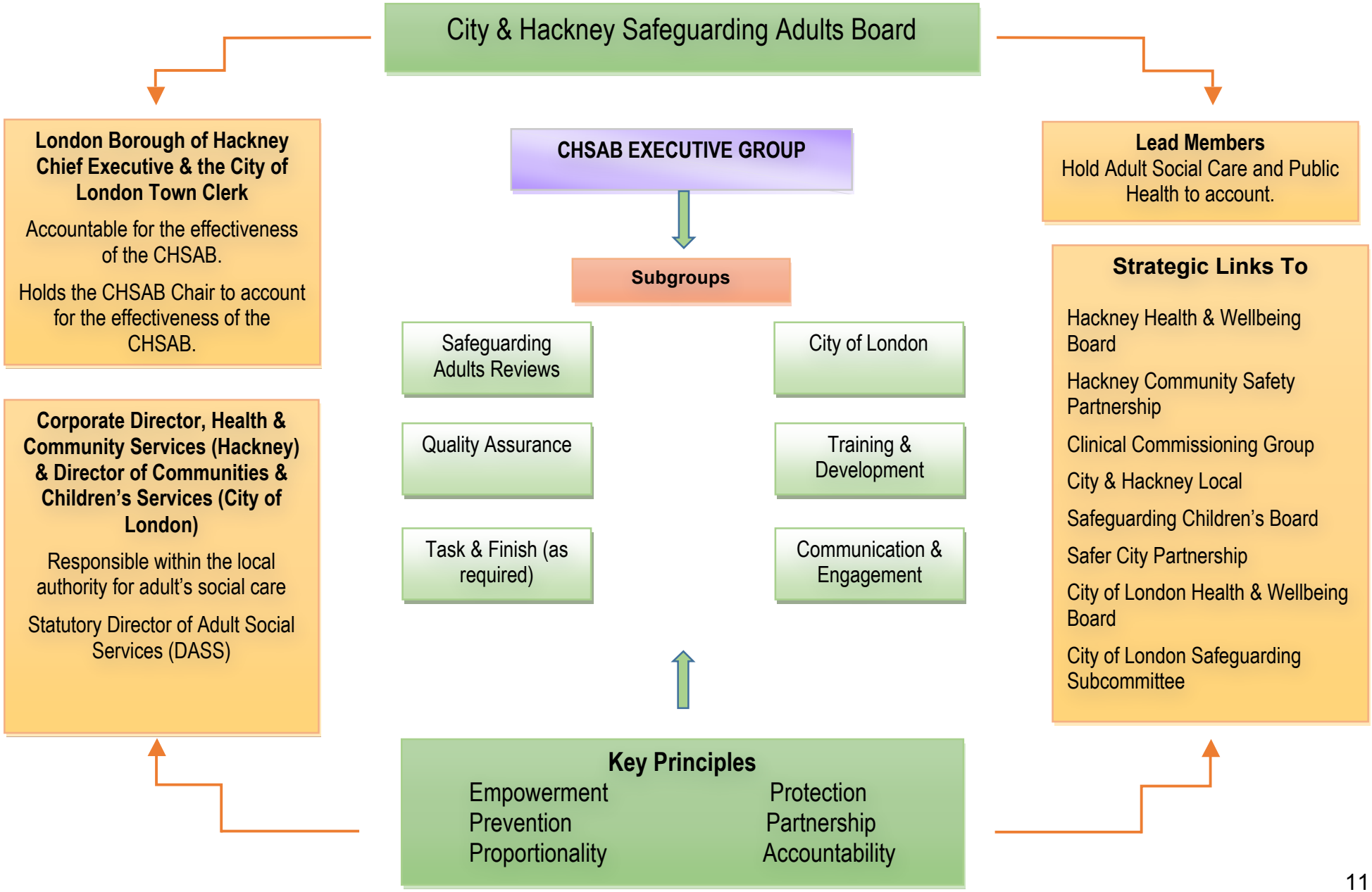
- The Hackney Community Safety Partnership & Safer City Partnership

- The City & Hackney Safeguarding Children's Board at strategic and operational levels. For example, both the London Borough of Hackney's Corporate Director for Health and Community Services and the City of London's Director of Community and Children's Services are members of the City and Hackney Safeguarding Children's Board. A senior practitioner from the Safeguarding Adults team now attends the operational forum of the Safeguarding Children's Board.

- The Hackney Health and Wellbeing Board and the City Health and Wellbeing Board. The Board's annual report is presented to the Health and Wellbeing Boards.

The City and Hackney Safeguarding Adults strategic governance arrangements are illustrated below.

City and Hackney Safeguarding Adults Governance



3.6 OUR SUPPORT TEAM

In 2014/15 a support team structure for the Board, which is independent of the London Borough of Hackney Safeguarding Adults team, was developed to establish clear lines of accountability and to ensure that the Board is able to hold all individual partners to account for the effectiveness of their safeguarding functions. This new structure was consulted on by the Board, contributions to funding are being made by a number of the partners to the Board and the team should be in place in September 2015. It will ensure that the London Boroughs of City and Hackney are fully compliant with the requirements of the Care Act 2014. This support team will include strategic lead, Board manager and administrative positions. The team will develop Board strategy and policies and provide key support to all partner agencies, to the independent chair and the subgroups.

3.7 OUR KEY ACHIEVEMENTS 2014-15

These are some of the Board's high level achievements as a partnership. See section 9 for further achievements by individual partner agencies during 2014/15.

- We developed our strategy for 2015 - 2020 and strategic plan for 2015/16
- We recruited a new independent chair (in place from June 2015)
- We developed our governance and subgroup arrangements
- We developed a support team structure
- We adopted a logo and new branding
- We developed the SAR process as per the requirement of the Care Act
- We developed a Safeguarding Adults protocol to meet the requirements of the Care Act (this will be further revised following publication of the Pan London policy and procedures in September 2015)
- We carried out the London Boroughs of City and Hackney safeguarding awareness campaigns

4 Our priorities 2014/15

The critical areas for development for the safeguarding adults system in City and Hackney over the last year were:

- to develop the Board governance arrangements and support structure (see sections 3.4 and 3.6)
- to continue building outcomes focused safeguarding practice and recording (see below)

- to build on our work to understand better the views and wishes of our service users and carers to improve practice and inform service development (see below)
- to further develop strategic arrangements with other boards (see section 3.5) and partners

Outcomes-focused safeguarding practice

We have continued to build on work already done to establish outcomes-focused practice with partner agencies. Examples of this include:

- The London Borough of Hackney implemented a new case recording system, Framework-i, in November 2014 and amended its safeguarding workflow to incorporate a focus on the person's desired outcomes in line with "Making Safeguarding Personal" (the City of London already uses Framework-i). Those who have been supported through a safeguarding service are routinely being asked whether they wish to be interviewed following a safeguarding intervention. The interview is used to obtain their views on the safeguarding service and whether their desired outcomes have been met.
- The police have reviewed their vulnerable adults framework to facilitate a greater emphasis on the person's decision making and wishes.
- The London Borough of Hackney took part a national pilot which endorses standards for services when meeting people's personal needs.

Raising public awareness

The Board continues to work to develop more effective ways of engaging with the community to raise awareness about abuse and neglect of adults at risk. In 2014/15 Safeguarding Awareness campaigns were held in both the City of London and Hackney. Their focus was to raise awareness of abuse and how to take action to prevent or deal with it. They included:

- A poster, factsheet and leafletting campaign accessing venues such as care homes, hospitals, doctor's surgeries, pharmacies, libraries, community halls and other community settings

- Stands at local events and attendance at targeted front of house services

- Case studies/media stories in Hackney Today and specific community newspapers

- Presentations on display screens in key organisations
- The use of on-line communities

- Accessible information was provided via translations, easy read, screen reader enabled documents, Braille and audio

- Yearly planned events included safeguarding adults participation, for example, the Big Do (for people with Learning Difficulties), Older Persons Reference Group event, and World Mental Health Day, and events for service users, carers and professionals such as Carers week.

Our safeguarding publicity material was reviewed to ensure Care Act compliance, with leaflets and pamphlets being widely available for the public. A "Making Safeguarding Personal" leaflet is now available on the Hackney website.

During 2014/15 there were 4,329 hits on the Safeguarding Adults section of the Hackney council website. This is a small increase on 2013/2014 when there were 4,027 hits**.** These figures will be kept under review in the year ahead

In 2014/15 Hackney Council provided training free of charge to 361 individuals from a range of organisations working with or representing adults at risk and their carers. The majority of delegates came from partner agencies, such as the voluntary sector and care providers. A training course on the safeguarding implications of the Care Act 2014 was provided. During 2014/15, 34 training events took place, an increase from the 28 training events held in 2013/2014.

There was 88% utilization of places in 2014/15, a decrease from 2013/14. This may have been due to the need for staff to prioritise attendance at Care Act training or, for Hackney adult social care staff, the need to attend Framework-i training.

Our work developing performance management and quality assurance across agencies working with adults-at-risk in the City and Hackney

Hackney adult social care staff worked closely with Homerton University Hospital NHS Foundation Trust on safeguarding cases and application of the Mental Capacity Act.

The Safeguarding Adults Team and the Board contributed to Public Health Outcomes and Hackney's Joint Health and Well Being Strategy across drug and alcohol misuse, community safety, violence prevention and social exclusion.

Case example: Ms CW

Ms CW is a 70 year old woman with a moderate learning disability, complex mental health needs and physical needs. Her nephew had physically abused CW in the past, taken large sums of money from her and emotionally manipulated her. He was released on licence from prison in 2014 and again took money from her and physically threatened her if she did not co-operate. In the past, CW had always refused to take any actions against her nephew because of her view that he is a family member and that he only acts in such a way because of his own mental health and drug problems.

This case involved a great deal of multidisciplinary working. CW's safety was the primary focus, but her personal views and expectations for the safeguarding process were central to the work being done.

The safeguarding alert was initially raised by the day centre that CW attended who reported that she had come in with her bank book which showed large abnormal cash withdrawals. CW said that her nephew was responsible for these withdrawals. Initial investigations found that CW's nephew was known to a local probation service and they were contacted regarding the allegations. Hackney adult social care worked with the probation service and the police in order to recall CW's nephew back to prison and whilst this was done, CW was moved, with her consent, to a place of safety.

Once she was immediately safe, attempts were made to address the long term issues, working with the police and the Hackney Domestic Violence Team (DVT). CW was interviewed by police but she was clear that she did not want her nephew prosecuted but she still wanted to be safe. Eventually, CW moved into a supported living scheme before her nephew was released from prison and a DVT solicitor and the social worker supported her to obtain a non-molestation court order to prevent her nephew from contacting her. This court order is enforceable by police and it is a crime to breach it which will hopefully prevent further abuse in the future.

Large amounts of psychological and practical support were offered to CW throughout this process, including from a trained learning disability clinical psychologist, to help her through the very difficult experience she had gone through. CW is now in a safe environment with the protection of a court order and the onsite care support.

Although police prosecution was not possible, there was very clear evidence that CW had been abused and in a case conference meeting held with CW and her family, we explained our findings to her to ensure that CW was informed throughout the process.

5 Our strategy 2015 - 2020

The outcomes that we will work towards over the next five years are:

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

The Strategic Plan for 2015/16 outlines what we are aiming for and what we expect to be different because of our joint work in delivering the strategy. Our Annual Development Day held in February 2015 agreed our strategic outcomes, guiding principles and planned objectives for 2015/16. During 2015/16 there will be a consultation on this strategy, as required by the Care Act 2014. The Board's 2015/16 Annual Report will evaluate progress, and consider what we have learned and changed.

6 Our priorities 2015/16

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

- Embedding the principles outlined in the Safeguarding Adults Strategy 2015-20 (see section 5) and achieving the milestones outlined for the 2015/16 strategic plan
- Ensuring that all safeguarding practice is underpinned by the six key principles in the Care Act (outlined in the introduction) and by the ethos of Making Safeguarding Personal

- Ensuring that the training needs of all partner agencies are understood and that safeguarding training (including training on the categories of abuse added by the Care Act) is available to, and taken up by, all partner agencies including the voluntary sector
- Embedding learning from Safeguarding Adults Reviews to improve practice via mechanisms such as a self-neglect protocol
- Developing strong links with the voluntary sector (including both commissioned and non-commissioned services) to enable increased service user and community engagement. This should include working with special interest groups (including faith and cultural groups) on prevention and early intervention in relation to safeguarding issues such as domestic abuse, FGM, forced marriage, domestic slavery
- Development of the Designated Adult Safeguarding Manager role and process (in each partner agency)
- Adoption of the Pan London Safeguarding Policies and Procedures and development of local supporting policies for City and Hackney
- Development of the Board's website
- Ensuring effective functioning of the five Board subgroups

7 Safeguarding Adults Reviews (previously known as Serious Case Reviews)

Safeguarding Adults Reviews (SARs) will replace Serious Case Reviews, following the introduction of the Care Act. The Board must carry out a SAR if a resident has died or experienced significant harm, abuse or neglect may have occurred, and there are reasons to believe that agencies and services could have worked together better.
One Safeguarding Adults Review was held in 2014-2015. This concerned Mrs A and Mr B who were residents of a supported housing complex. Mrs A was being supported by adult social care and Mr B was known to mental health services. There were concerns that Mr B posed a fire risk to the other residents. Mr B allegedly sexually assaulted Mrs A in her flat and was arrested. Mrs A was admitted to hospital and was discharged to a nursing home.

The review identified the need to improve risk assessments for new residents of supported living so as to look in more detail at how a scheme as a whole might be affected by a new resident. The review also identified areas for improvement in staff training and development, and the need for better ways of drawing concerns to the attention of senior managers in complex cases. It was also recognised that improved multidisciplinary working (including better communication) is required.

Finally, the review asked the Safeguarding Adults Board to develop improvement plans in two particular areas: working with sexually active older people, and managing fire risk. The Board has accepted the findings and recommendations of the review and has incorporated them into its strategic plan. A summary report will be published on the Board's website as a separate document.

Case example: Mrs B

Mrs B, a 65 year old Hackney resident was referred to adult social care by a concerned neighbour who was worried that she was being financially abused by another neighbour. Mrs B takes various medications for her physical and mental health issues and manages her care needs with support from her family.

The social worker visited Mrs B who reported that her family help administer her medication on a daily basis as she has a history of overdosing. However she keeps some medication herself and her neighbour had started asking her for money and certain medications. Mrs B advised that she had only agreed to this as when she tried to say " no" she felt pressurised.

Mrs B initially asked the social worker not to tell anybody but following a discussion about what was the best way forward and what outcomes she wanted, agreed that the social worker could speak to her daughter about what was going on.

The social worker informed the daughter who drove over to Mrs B's house to take the excess medication. Mrs B, her daughter and the social worker decided that it would be best if the family administered all medication so that if the neighbour asked Mrs B for any medication she would be able to say that now her family were administering all medication and so she didn't have anything to give. Mrs B also agreed that her daughter should take her shopping and look after her money so that if her neighbour asked for cash she would also again not have access to it.

Mrs B was adamant that she did not want this safeguarding issue investigated further or the police involved. She reported to feeling a load off her chest when, with the support of the social worker, she had been able to tell her daughter what was going on. She had previously been anxious that her daughter would be angry with her. She wanted to maintain a reasonable relationship with her neighbour but not to have to give him money and her medication. Mrs B identified that her desired outcomes were achieved through the safeguarding process and that she felt involved in the decision making process.

8 Reports from individual agencies

8.1 City of London

Overview

The City of London Adult Social Care Team seeks to safeguard adults at risk who are primarily part of the resident population of 7,400 within the square mile. Life expectancy within the City of London is very high but brings with it an increase in age related health difficulties such as reduced mobility, increased physical and cognitive frailty including dementia and social isolation, creating a greater need for care and support. The team also works with adults with mental health, learning and physical disabilities, their loved ones and carers, and seeks to safeguard these groups also.

As part of the Care Act implementation in April 2015, work was done to instil in our community providers the importance of the early intervention, prevention and wellbeing agenda. Full training sessions have been run around all elements of the Care Act, including safeguarding with partners including police, community health and housing together with commissioned providers, our adults community group, carers group, and dementia group and volunteer service (befrienders, including dementia specialist volunteers, shopping service and handy man scheme) together with our Care Navigator.

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

Support, challenge and scrutiny of adult safeguarding practices have continued to be demonstrated through the framework of the elected member Safeguarding Subcommittee together with the officer-led Subcommittee of the City and Hackney Safeguarding Adults Board. Service user representation on this committee gives the service user a voice within the agenda and gives challenge and scrutiny to the work of the subcommittee. Quarterly Safeguarding data is presented to both committees.

In February 2015 an external independent quality assurance audit was undertaken in relation to all 2014/15 practice within Adult Social Care, both operational and strategic. An Improvement Plan, alongside a tool kit, a case audit and Safeguarding Adults Team appraisal objectives have been developed as a response and will be presented to both subcommittees for approval in the autumn.

City of London has played a full part in the development of the Board five year strategy at SAB development days and through discussion at the subcommittee.

City of London has taken ownership of the strategy as a partner of the Board.
City of London is currently represented as a member of the SAR subgroup, and will be chairing a SAR in the autumn.

City of London Adult Social Care Service currently knows of 350 people, either placed outside the city in residential, nursing or supported living placements or living in the city.

The Adult Social Care Service comprises of an in-house reablement service of three and an Occupational Therapist. There are five social workers (one locum social worker in addition to the establishment to cover the additional Deprivation of Liberty Safeguards work) including one Approved Mental Health Professional, a Care Navigator (a one year pilot with Age UK), two finance and administrative support officers, the Senior Practitioner (a new post to the team in 2015), the Team Manager and Service Manager. The team takes on all safeguarding work that comes in.

The Adult Social Care Service has worked with One Hackney throughout its development as partners within the Better Care Fund plan and as part of the South West Quadrant (part of the One City and Hackney Model) in conjunction with the one City of London GP practice. Services offered through One Hackney are accessible to all City of London residents and there has been extensive work carried out this year to look at cross border issues and the importance of equity of service to all and seeking to ensure that no one slips through the net and thus becoming a potential adult at risk.

Work reported on in the 2013/14 annual report with LFB has been completed. Ordering of telecare heat and smoke sensors is carried out on a case by case basis.

The Supported Assessment Questionnaire has a fire safety check question for all social workers to adhere to as part of the full assessment process.

The City of London Police have introduced a new standard operating protocol 'Adults at Risk', which provides a vulnerability assessment framework for staff to identify vulnerability and then the appropriate process to follow to report this and safeguard vulnerable adults. This is in line with the Metropolitan Police Service's toolkit. In addition the protocol clarifies safeguarding procedures between the City of London Police and City of London Adult Social Care team and the investigation of cases of adult abuse. A new process has been introduced for recording 'Adults Coming to Notice' (similar to the Metropolitan Police Service's Merlin system, see section 10.1) as this was previously done on the same electronic form as a child coming to notice, which caused City of London Police difficulties with searching and extracting data. The new operating protocol, the vulnerability assessment framework and the 'Adult Coming to Notice' system are now fully live.
In addition, Public Protection Unit staff, who deal with investigations in to adult abuse and the referrals to Adult Social Care, have undertaken Care Act training with the local authority.

Safeguarding Activity

- The number of safeguarding alerts received from April 2014 to March 2015 was **29**. **22** were within the City of London. In 2013/14 were 28 with **16 w**ere within the city. In 2012/13 there were 20 with **14** within the City.
- As a host authority, City of London has hosted three safeguarding cases from Bart's Health Trust as regards alerts raised pertaining to transport.
- There are currently 32 Deprivation of Liberty Safeguards cases, two of which are pending in the Court of Protection as they involve supported living situations. There are nine Relevant Person's Representatives currently working with people in placements.

Key Developments

- The Notice the Signs Safeguarding Awareness Raising campaign was a key feature of 2014 work in the City and the campaign to residents has been a great success in relation to an increase in the number of community referrals, including those from residents. The written feedback from five public consultations within the city over 2014 and early 2015 has shown that adult safeguarding has been placed on the public's agenda and this, together with the 2015 safeguarding training under the Care Act, has really raised the profile of safeguarding being "Everyone's Business". This has been evidenced by the rise in alerts received to the service.
- There has been increased multi-disciplinary attendance at strategy and conference involving GPs and Police, care agencies, and the adult at risk and their Advocate or family member.
- Some really successful Domestic Abuse safeguarding adults work was carried out with City of London police. Regular meetings with police have taken place and attendance at all Multi Agency Risk Assessment Conferences and Multi Agency Public Protection Arrangements meetings.
- Work with Carers UK was carried out to review and develop the City of London Carers Strategy for full Care Act compliance. The strategy will be presented to the Department for Community and Children's services in September 2015 for approval.
- Safeguarding Carers was a key focus of the original Adults Improvement plan 2013/14 following the initial Quality Assurance inspection that was undertaken jointly with Hackney. The need for respite care and the use of Carers' Individual Budgets have been part of protection plans regarding preventing significant harm through carer pressures.
- Making Safeguarding Personal has become an intrinsic part of the 2014/15 City of London Adult Social Care Improvement Plan, with the emphasis on the involvement of the person and advocates throughout the safeguarding process. City of London is adopting the Hackney borough's Making Safeguarding Personal Safeguarding Adults forms to provide a consistent reporting process for capturing this qualitative data.
- The increase in work around Mental Capacity and Deprivation of Liberty Safeguards has placed considerable resource and time pressure on the generic adult social care service and will be a key feature of the coming years safeguarding work with legislative changes around Deprivation of Liberty Safeguards being planned for 2016.

- There has been a key drive to develop a Think Family approach in the City of London, both internally across the people's directorate as well as working with partners. There is a move towards even greater assimilation with children's services in the City. Protocols have been implemented around Transitions and Children and Adult Mental Health. The safeguarding messages to officers and partners regarding the above are clear.
- Co-production continues to be a key element of all practice and commissioning within the City of London, and we continue to have a very strong Adult Advisory Group.
- There is ongoing discussion about developing this public consultation element even further with the development of an intergenerational People's Forum, which utilises Time Credits to reward people for their time, views and input.

Training

- All Adult Social Care staff have Safeguarding Adults training that is appropriate to their experience and grade as part of their appraisal objectives. This training is accessed via the London Borough of Hackney as partners of the Safeguarding Adults Board.
- It would be hoped that more training dates will be becoming available as partners have agreed to fund their membership of the Board and therefore have increased access to Hackney's full Safeguarding training suite, to ensure enhanced skills and a fully trained workforce. It would also be hoped that City-specific training could be arranged with partners during 2015/16.
- All City of London staff have had access to *Prevent* Strategy[1] training and the Community Safety Project Coordinator has attended both Adult Advisory Group and Safeguarding committees.
- There is a City of London Domestic Abuse strategy and forum and all staff have been offered domestic abuse training via City of London Police.
- All frontline City of London Police officers and staff have received a training input on the service's new operating protocol, vulnerability assessment framework and the 'adult coming to notice' system.
- Full Care Act training was rolled out to staff and partners prior to April 2015. Safeguarding under the Care Act has been a key focus within the Adult Social Care service and is developed within the Improvement plan.

Priorities and plans for 2015/16

- To implement fully the Safeguarding Improvement Plan, a Safeguarding Adult Manager's Checklist, a Practitioner prompt sheet, a Practitioner 10 point checklist, the Making Safeguarding Personal Guide and Internal case audit forms.

[1] The *Prevent* Strategy is part of the Government's counter-terrorist strategy (CONTEST). Its aim is to stop people becoming terrorists or supporting terrorism.

- To develop the draft City of London Police Vulnerability and Protection of Adults at Risk Standard Operating Procedure and continue to work closely with the police and Trading Standards around Safeguarding and Scams.
- City of London Police to look at options for a 'virtual' Multi Agency Safeguarding Hub and although this will start with children only cases, the service will be looking to progress to adults in due course.
- To work with the independent Board chair through the corporate Board structure to deliver the key objectives contained within the safeguarding strategy.
- To continue to offer quarterly City of London Safeguarding Champions forums to maintain Safeguarding and "Notice the Signs", as a core skill for all public facing departments throughout the Corporation of London.
- To develop the role of the Designated Adult Safeguarding Manager and work with the City of London Local Authority Designated Officer to shape City protocol and practice across Adults and Children services.
- We look forward to the finalising and publishing of the London Multi Agency Safeguarding Adults policy and procedures together with the work of the newly appointed independent City and Hackney chair.

8.2 London Borough of Hackney

Overview

The Safeguarding Adults Team (SAT):

The Team's main functions are to be the initial point of referral for safeguarding concerns, to develop practice within Hackney adult social care and to work in partnership with external agencies to improve outcomes for Hackney residents.

It represents the service at the:

- Multi Agency Public Protection Panel
- Multi Agency Risk Assessment Conference
- East London Foundation Trust Safeguarding Committee
- Antisocial Behaviour panel
- Safeguarding Children's Board (operational forum)
- Prevent panel
- Board and several of the subgroups

- London Adults Safeguarding Network

As the single point of entry for all safeguarding concerns within adult social care, the team determines whether the adult at risk is known to adult social care or health services and asks the appropriate department to investigate.

The team also provides expert advice and support to internal and external colleagues/agencies. This may include attending strategy meetings, giving advice face to face or over the phone, liaising with Care Quality Commission, London Borough of Hackney's legal department, etc. The team manages Deprivation of Liberty Safeguards applications and has one senior practitioner responsible for Mental Capacity Act/Deprivation of Liberty Safeguards duties and one senior practitioner who is a Community Safety lead. Both senior practitioners are Safeguarding Adults Managers. The team does not hold or directly manage cases although it may have a significant involvement in complex situations. The senior practitioners will attend safeguarding meetings when the person is living out of Borough or where the concern raised is not regarding a named individual (for example, a concern is raised about general work practice in a ward or care home where there is no Hackney resident).

The Deprivation of Liberty Safeguards senior practitioner provides deprivation of liberty training to internal staff and external partners and is also responsible for work such as developing and revising practice guidance for managing authorities, keeping abreast and briefing colleagues, senior managers and partners on case law and national developments.

The team produces a bi-monthly safeguarding newsletter for staff and chairs a Deprivation of Liberty Safeguards best practice forum to assist good practice across Adult Social Care.

The team also supported the Board in terms of production of information, organisation of meetings etc. This function will cease when the new Board support team starts in September 2015.

Adult social care

Hackney Adult Social Care introduced Framework-i as its client recording system in October 2014, which has enabled better recording of the desired outcomes of a person who experiences the safeguarding service and whether or not these have been achieved. As a result Hackney has improved, providing a more person-centred approach with reports that can be used to inform strategic development.

Safeguarding has become a standard agenda item in social work supervision, with an emphasis on person–centred practice. It has also become a standard agenda item at locality meetings. Written guidance on Making Safeguarding Personal has been provided to staff and is available on the Hackney website.

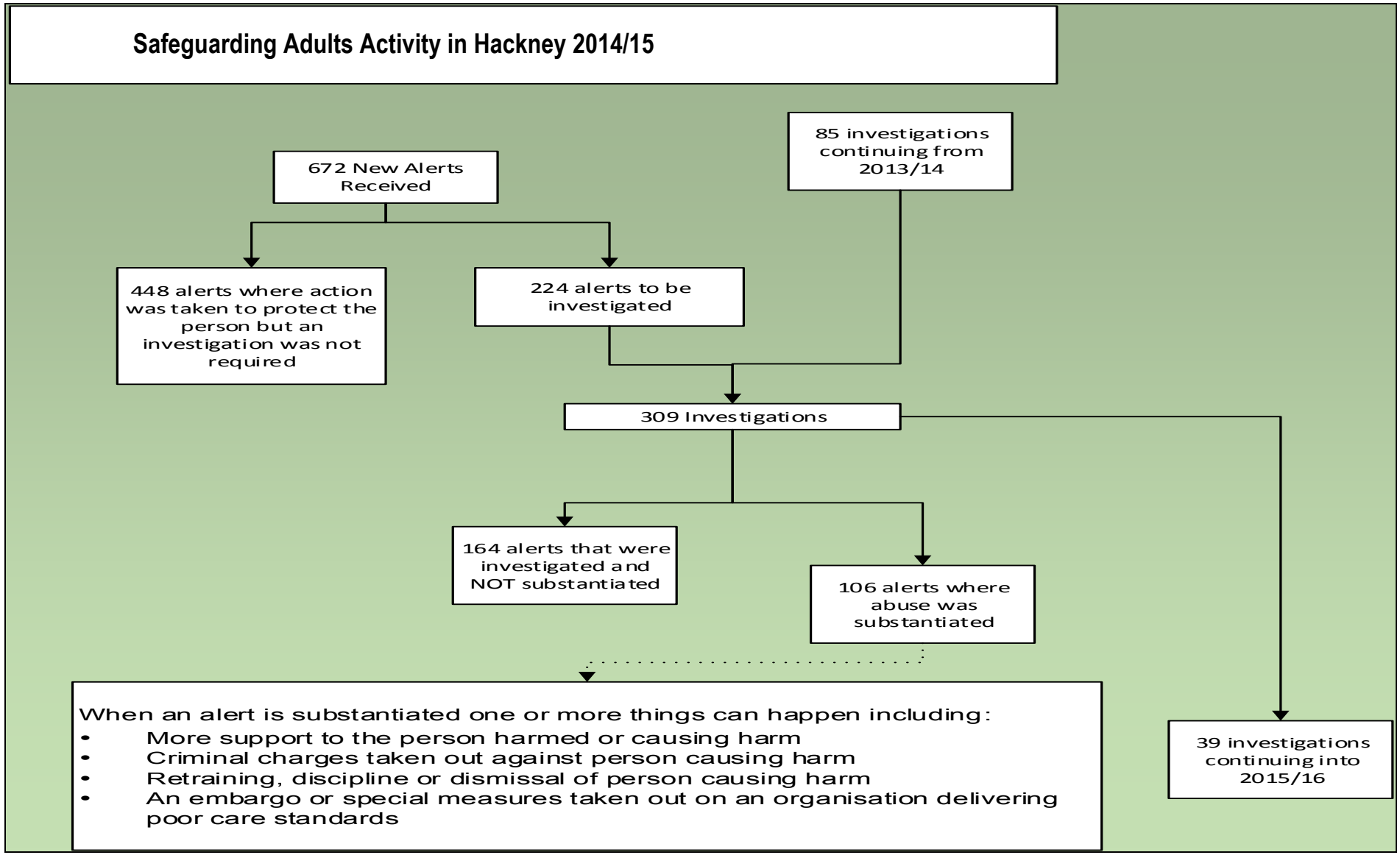
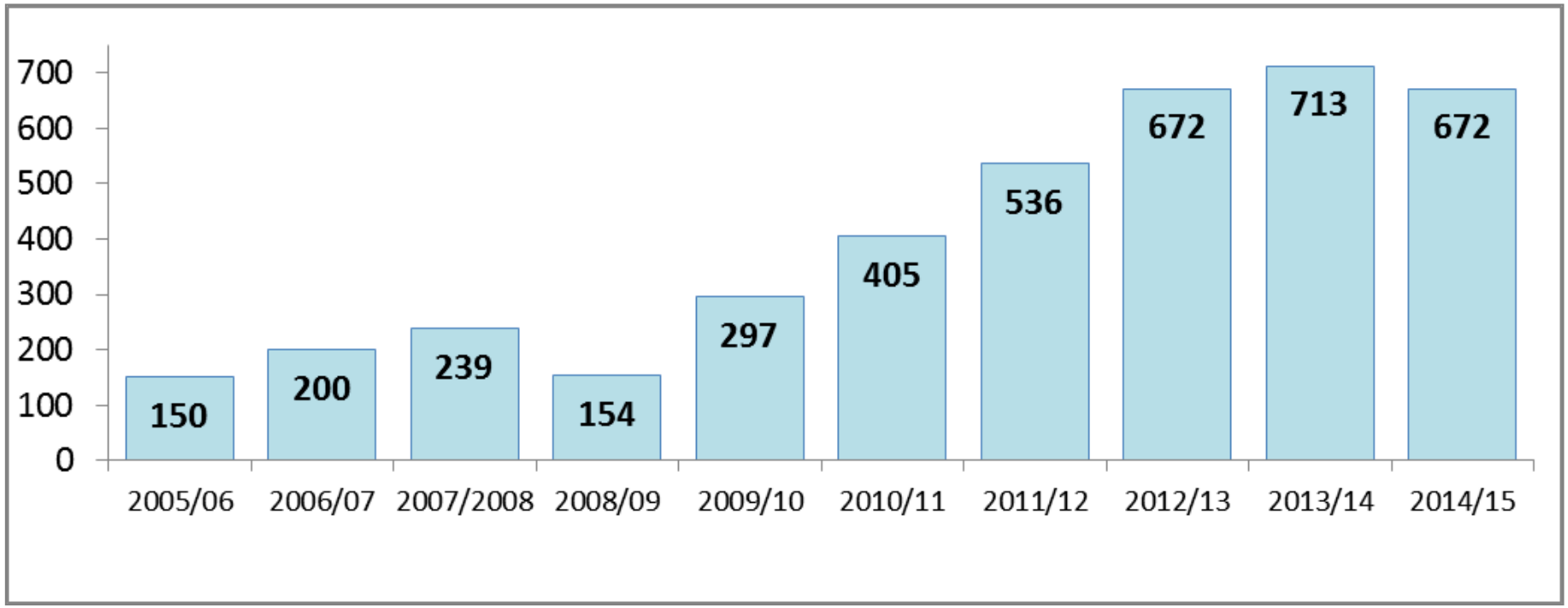

Safeguarding Adults Activity in Hackney 2014/15
672 New Alerts Received
85 investigations continuing from 2013/14
448 alerts where action was taken to protect the person but an investigation was not required
224 alerts to be investigated
309 Investigations
164 alerts that were investigated and NOT substantiated
106 alerts where abuse was substantiated
39 investigations continuing into 2015/16
When an alert is substantiated one or more things can happen including:
• More support to the person harmed or causing harm
• Criminal charges taken out against person causing harm
• Retraining, discipline or dismissal of person causing harm
• An embargo or special measures taken out on an organisation delivering poor care standards

Figure 1: Alerts to Adult Safeguarding Procedure 2005/06 to 2014/15 (Hackney)

Source: SAR[2] and local information from 2005/06 to 2014/15



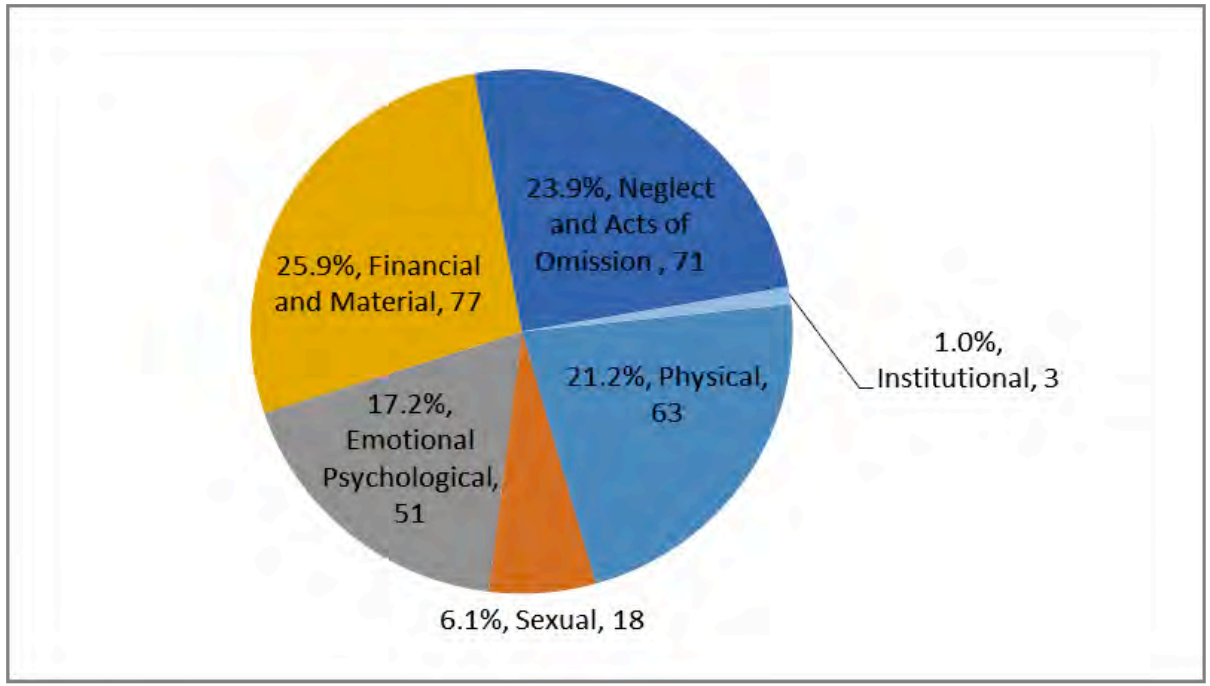
There was a decrease in safeguarding alerts in 2014/15 compared to 2013/14. However, the general increase in alerts over the previous four years suggests people have responded to our communications and training programme. We received 672 safeguarding adult alerts in 2014/15, coincidently the same number as in 2012/13. The alerts remain at a high level compared to those from five years ago, although the trend of increasing alerts year-on-year has stabilised.

Type of abuse

[2] The Safeguarding Adults Return (SAR) is an annual statutory return for Local Authorities. The SAR addresses various aspects of safeguarding, with particular regard to the details of the victim, the alleged perpetrator and the alleged offence.

Financial abuse remains the most prevalent type of abuse (25.9%) although there has been a reduction in cases of financial abuse since last year. Cases of neglect and acts of omission remain at the high level recorded last year, with 23.9% of cases reporting this type of abuse.

Figure 2: Alerts accepted for investigation and action under safeguarding adults procedures by type of abuse perpetrated (Hackney)
Source: SAR 2014/15. There can be more than one type of abuse identified for a single case, 54 cases investigated in 2014/15 had multiple types of abuse investigated.

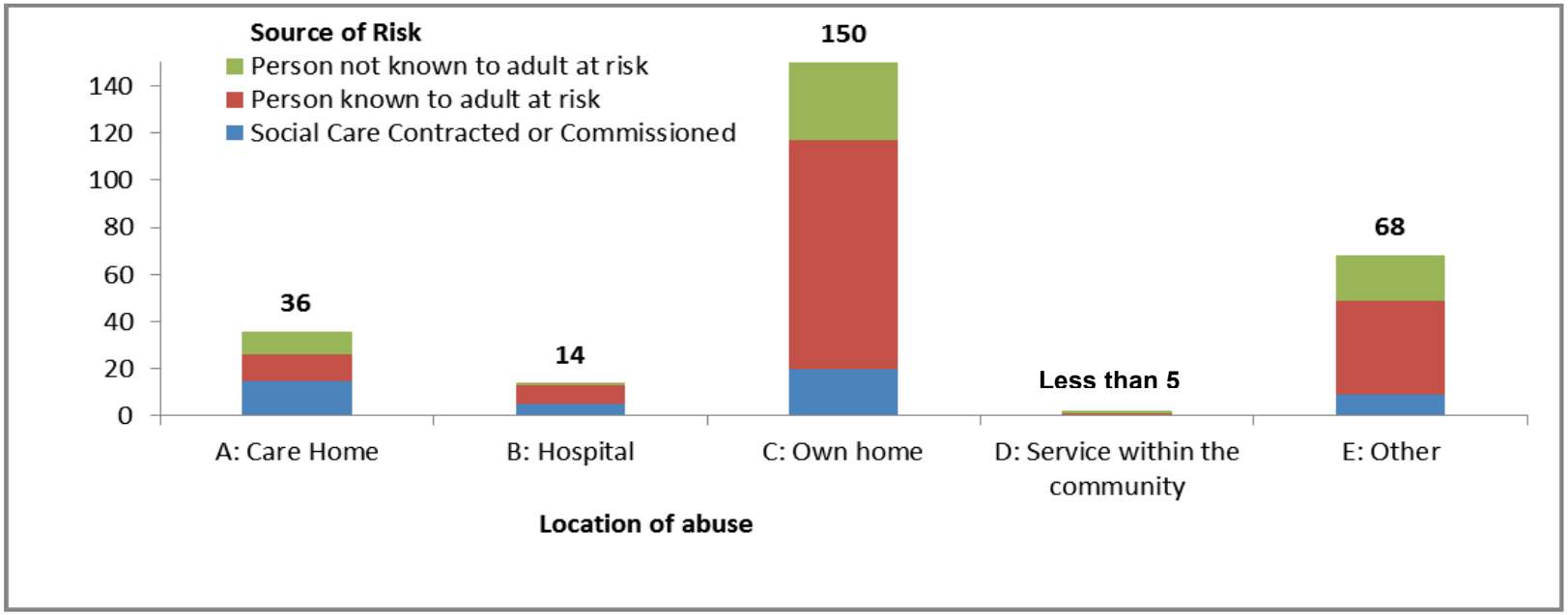


Repeat Alerts
Some adults at risk will have more than one safeguarding alert raised in a year. The Hackney Safeguarding Adults Team received 672 safeguarding alerts in 2014/15 for 641 people. 613 adults at risk had one alert raised in 2014/15, 26 had two raised, one had three, and one had four raised. Of the 29 *repeat* alerts, 16 (55%) went on to receive a safeguarding investigation, and of these 16 investigations there were six cases where abuse was substantiated or partially substantiated.
In 2015/16 we will be analysing reasons for repeat alerts and consider what work could be done to prevent repeat alerts in the future.

Location and Source of abuse

Figure 3 & Table 1: Completed safeguarding investigations by location of abuse and source of risk for the vulnerable adult (Hackney)

Source: SAR 2014/15



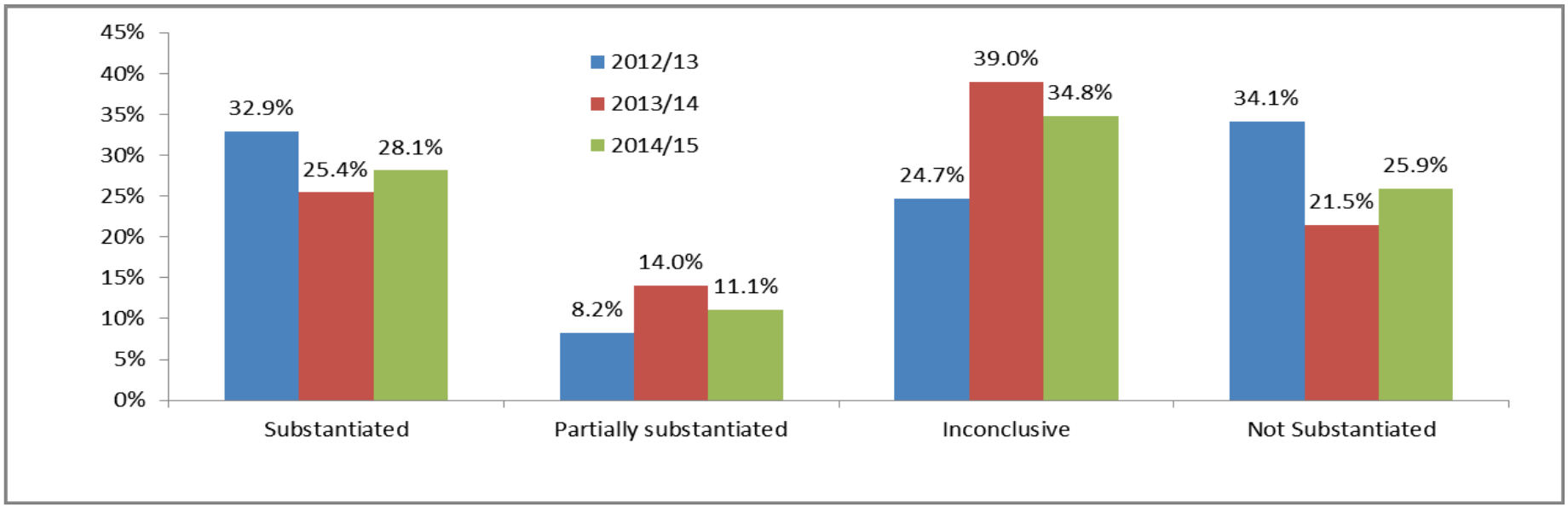
Location of abuse	Social Care Contracted or Commissioned	Person known to adult at risk	Person not known to adult at risk	Total
A: Care Home	15	11	10	36
B: Hospital	5	8	< 5	14
C: Own home	20	97	33	150
D: Service within the community	0	< 5	< 5	< 5
E: Other	9	40	19	68

The high percentage of abuse of people by someone they know is confirmed again this year in our analysis of the 270 completed safeguarding cases. 58% of investigations found the source of risk to be known to the adult at risk. 56% of investigations also found that the location of abuse was the victim's own home. The prevalence of domestic abuse by family members is consistent with previous analyses.

Investigation Outcomes

Figure 4: Outcomes[3] of completed safeguarding investigations, 2012/13, 2013/14 and 2014/15 (Hackney)

Source: SAR 2012-15



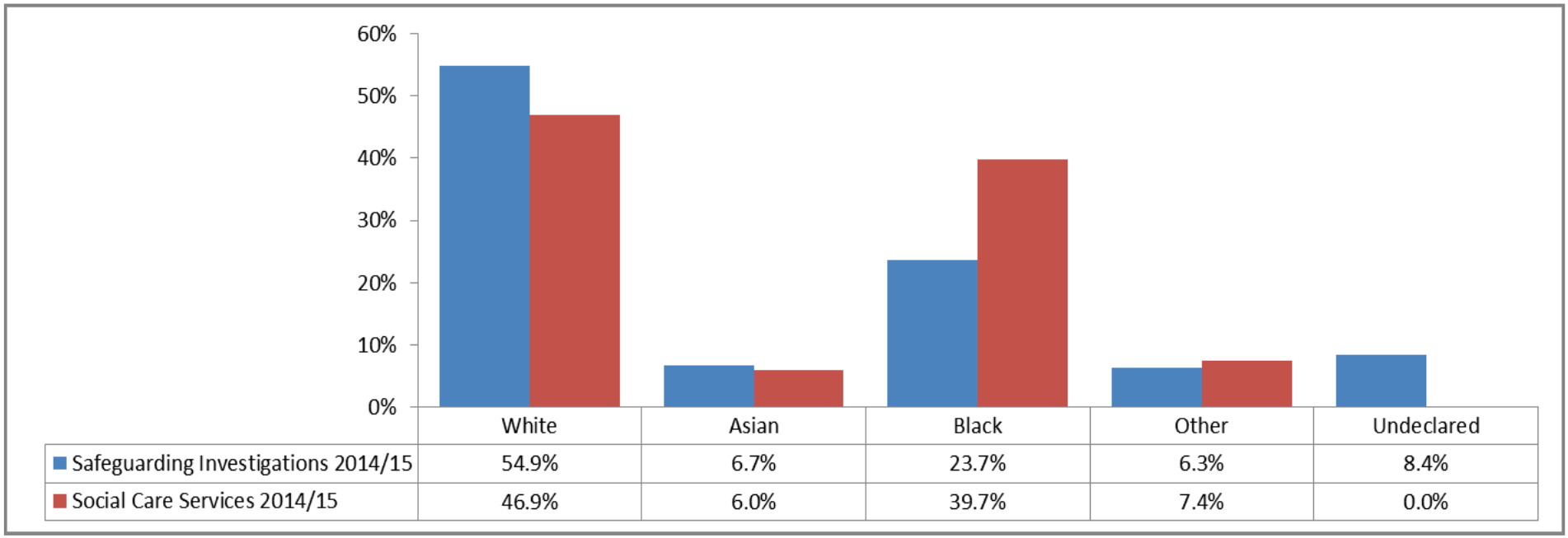
[3] *Substantiated*: All the allegation(s) of abuse can be proved on the balance of probabilities.
Unsubstantiated: The allegation(s) of abuse in an investigation cannot be proved on the balance of probabilities, i.e. there is not enough evidence to support any of the allegation(s) or there is evidence to disprove all the allegations (or a combination of these two).
Partially substantiated: Some but not all allegations of abuse can be proved on the balance of probabilities.
Inconclusive: When it is not possible to record the outcome of the investigation against any of the other outcome categories.

As with last year's data there are more cases where the outcome is 'inconclusive' rather than 'not substantiated', which may indicate more complex investigations taking place[4]. There is a close correlation between the three years of data. Further analysis of these results is required to understand the high level of inconclusive investigations.

Ethnicity of adults-at-risk

Figure 5: Comparison of the ethnic profile of accepted safeguarding cases with the ethnic profile of Service Users receiving Adult Social Care Services 2014/15 (Hackney)

Source: SAR 2014/15



	White	Asian	Black	Other	Undeclared
Safeguarding Investigations 2014/15	54.9%	6.7%	23.7%	6.3%	8.4%
Social Care Services 2014/15	46.9%	6.0%	39.7%	7.4%	0.0%

There is a notably greater proportion of members of the black community who are receiving long term support from Hackney compared to the proportion of the same community who are the subject of safeguarding investigations. Conversely, the proportion of white members of the community receiving long term services is significantly smaller than the proportion who have been the subject of safeguarding investigations. Further analysis will be required for Hackney as the Department of Health ethnicity requirements for the SAR are minimal and do not account for the large ethnic mix in the borough – in particular the Jewish Community must be included as White for Department of Health returns. It is also notable that we have no undeclared ethnicities recorded for Social Care Services because of a change in the way in which data is recorded for long term services on our new Social Services Database. This will also be the case next year when all safeguarding data will come from the same system.

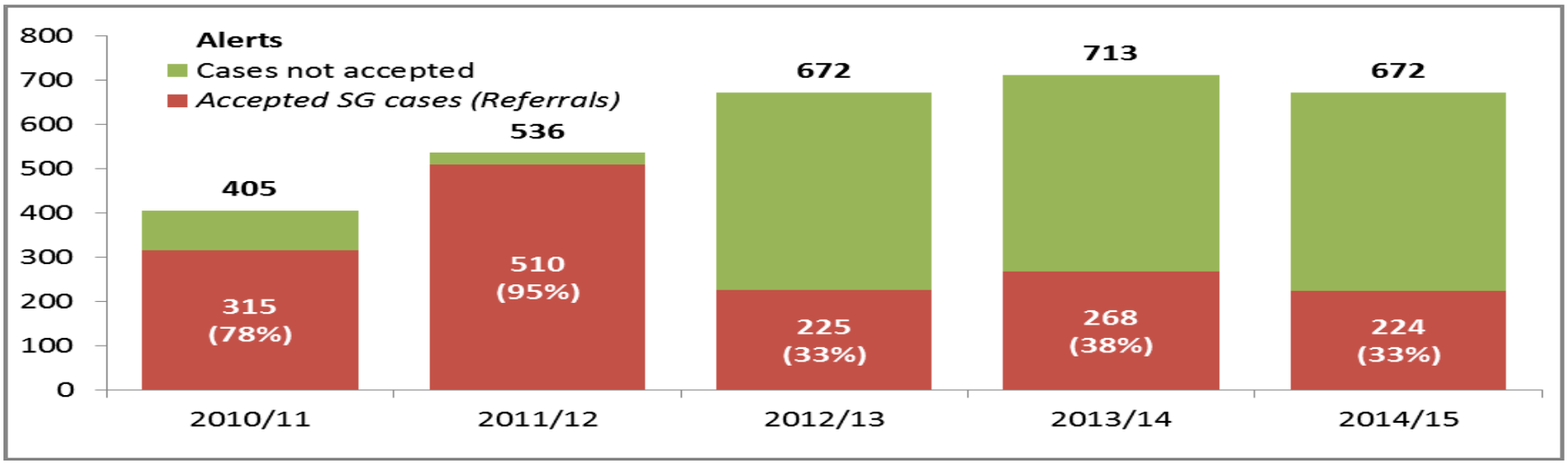
Gender of adults at risk

Females have a slightly higher proportion of safeguarding alerts at 52%. This is a consistent pattern.

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

Figure 6: Analysis of Safeguarding alerts and proportion of cases accepted for investigation 2010-2015 (Hackney)

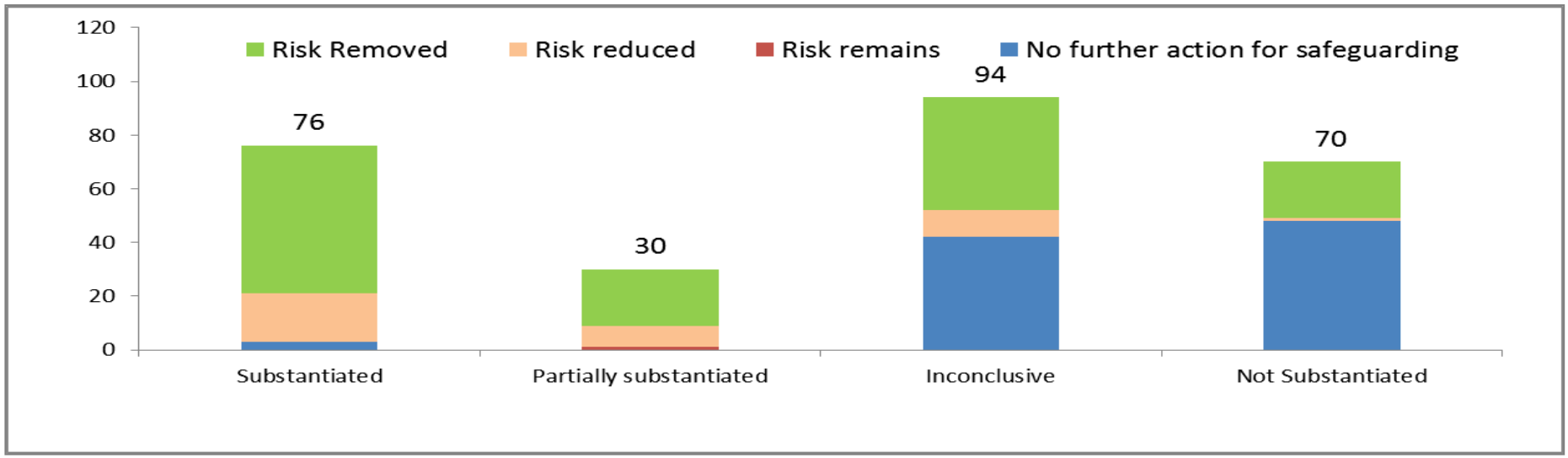
Source: SAR 2014/15



The proportion of alerts that became accepted safeguarding cases has slightly reduced since last year from 38% to 33%.

Actions taken to safeguard adults-at-risk

Figure 7: Outcomes of completed safeguarding investigations 2014/15 with further outcomes from the updated SAR data fields (Hackney)
Source: SAR 2014/15



In cases where investigations did not substantiate that abuse had taken place, there were efforts made in a large proportion of cases to make people safer and remove any possible risks.

Safeguarding alerts by client group for the last three years
The number of alerts regarding adults at risk with substance misuse issues has dropped down its lowest levels. The number of adults at risk with learning disabilities has also reduced by 9%. Alerts from older people with mental health problems has reduced to the levels seen prior to last year. Further investigations of these figures is required to ascertain whether or not this is a recording anomaly or whether there are practice issues.

Table 2: Safeguarding alerts 2011-2015 by client group and age (Hackney)
Source: SAR 2011/15

Age Range	Client Group Category	2011/12	2012/13	2013/14	2014/15	% difference 2013/14 to 2014/15
18 - 64	Physical Disabilities	92	124	121	103	-15%
	Mental Health	102	132	141	171	21%
	Learning Disabilities	85	84	106	96	-9%
	Substance Misuse	18	48	12	6	-50%
18 - 64 Total		297	388	380	375	-1%
65 +	Older People	176	222	226	220	-3%
	Older People with Mental Health Problems	63	62	107	70	-35%
65 + Total		239	284	333	297	-11%
Total		536	672	713	672	-6%

Deprivation of Liberties Safeguards Activity Data 2014-2015 (Hackney)

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

The Safeguarding Adults Team is Hackney's "supervisory body", responsible for giving authorisations for deprivations of liberty for people residing in care homes or hospitals, when the relevant criteria are met. Family members and friends may contact the supervisory body to express concerns over possible deprivation of liberty.

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

In 2014/15 there were 344 applications for deprivations of liberty. 38 had the applications withdrawn and six applications were not signed off at the time we completed our statutory return. Of the remaining 300 applications 270 (90%) were approved and 30 (10%) were not granted. This is a considerable increase in Deprivation of Liberty Safeguards applications from 2013/14, when there were only 23 applications for Deprivation of Liberty Safeguards authorisations, of which 13 (57%) were approved. 118 (39%) of the 300 applications were urgent requests and 83 (70%) of these were completed within the statutory timescales of 14 days. The remaining 35 (30%) were not completed on time. 182 (61%) of the 300 applications were standard requests and 138 (76%) of these were completed within the statutory timescales of 21 days. The remaining 44 (24%) were not completed on time. The most common reason for delay was the non-availability of assessors to complete the assessments within the timescale. A report in Community Care (August 4th 2015) stated that of applications received by the 93 councils from April to June 2014, 28% had either still not been signed off by the supervisory body or had been withdrawn by the provider. The proportion of cases not signed off or withdrawn rose to 48% for applications received in July to September 2014, 58% for October to December 2014, 67% for January to March 2015 and 71% for April to June 2015. Based on these figures, Hackney is performing at a comparatively high level in managing the Deprivation of Liberty Safeguards applications.

The increase in applications was predicted following the Supreme Court's judgment in the "Cheshire West" case in March 2014 (see Appendix 2 for more information regarding this landmark decision). Hackney has responded to this challenge in a number of ways:

- Recruiting and training more Best Interests Assessors to carry out Deprivation of Liberty Safeguards assessments
- Making use of independent Best Interests Assessors when necessary to meet demand
- Keeping up to date with case law and Department of Health guidance to prioritise the most complex cases.

The following issues are still proving challenging due to the substantial increase in demand:

- Obtaining input from IMCAs in a timely way to inform the authorisation process
- Getting up to date information from hospitals to prevent assessors turning up to assess a patient who has already been discharged
- Finding assessors for service users placed outside greater London so as to keep within the statutory timescales
- Securing representatives for service users placed outside greater London who do not have family or friends

In the year ahead we expect to receive around 650 Deprivation of Liberty Safeguards applications which will put even greater pressure on the supervisory body. We will continue to review how to make best use of our resources so as to provide this vital human rights protection to some of the most vulnerable members of our community. A benchmarking/outcomes appraisal report is scheduled for autumn 2015.

Following widespread criticism of the Deprivation of Liberty Safeguards process the Government commissioned the Law Commission to draw up proposals for a new system. These were published in July 2015. Further details will appear in the Board's report for 2015/16.

Winterbourne View update

As a result of the Winterbourne Concordat, Hackney Learning Disability services introduced a range of measures to ensure those that those who presented with behaviour that challenges were supported in appropriate settings within the community of their choice.

All individuals who had been placed in-patient units were reviewed using the Care Programme methodology and a number have been discharged. Currently there is one remaining person receiving therapeutic support within a specialist setting. This individual has named workers within the service who visit regularly and monitor the treatment schedule.

There is a specific team in place who have responsibility for supporting those who present with behaviours that impact on their presence in the community.
Work has been undertaken with local providers to develop services that are able and skilled in supporting those with complex needs locally as alternatives to in-patient and/or secure settings.

Key developments

- In 2014/15 we worked hard to prepare for the implementation of the Care Act. We set up a subgroup to steer this work and ensure adherence to timescales. A comprehensive staff manual was produced which included a safeguarding section and our safeguarding publicity was reviewed in line with the Care Act and made widely available to the public.
- We published a safeguarding awareness pack for people who pay for their home care with a direct payment. The pack is also useful for people who fund their own care.
- We published a Making Safeguarding Personal leaflet onto our website for professionals and the public.
- We took part in a Department of Health pilot study on how we are making social care more personalised and carried out 20 face to face interviews with adults at risk in 2014.

- The Adult Social Care case recording system's safeguarding work flow was revised in line with the Care Act to include recording the person's desired outcomes.
- Every person who goes through the safeguarding process is now asked at the end if they wish to be interviewed about their experience
- We ran a safeguarding awareness campaign to continue to help diverse communities in Hackney to understand how safeguarding adults can support them and should see the impact of this in 2015/16.
- We liaised with colleagues on other London boroughs via forums such as the London Safeguarding Adults Leads Meeting and the Deprivation of Liberty Safeguards Leads Meeting.
- Our Commissioning Team checked 26 care homes to see how well they listened to residents and relatives and met people's needs (21 care homes in the Borough in which Hackney residents are placed and five homes in the Borough where there are no Hackney residents). We worked closely with the Care Quality Commission to ensure a co-ordinated approach in response to issues that arose in the homes and worked with other local authorities where Hackney service users live. We continued to seek improvements in the quality and integration of intelligence about standards of care, and in the robustness of responses to poor quality.
- We closely monitored 17 home care agencies in Hackney and liaised with the Care Quality Commission to improve performance and developed quality standards which take into account the views of people who have undergone safeguarding, their families and their carers
- There is an internal protocol for rapid responses to concerns about providers to ensure co-ordinated and proportionate action is taken by officers within the Safeguarding Adults Team, adult social care and learning disability services, and contracts and commissioning teams.
- The Quality Assurance and Safeguarding Board met on a monthly basis. Its purpose is to ensure the delivery of high quality services which are preventative, promote independence and support Hackney citizens to meet personalised outcomes within a safe environment. It shares information across commissioning, safeguarding, health and adult social care in relation to quality, performance and value for money and agrees actions to be taken in relation to providers (in accordance with the specification of the Council and the requirements of Care Quality Commission or other regulatory or commissioning bodies).
- The Quality Assurance and Safeguarding Board carried out extensive work in 2014/15, including creating an internal embargo policy, reviewing forms in light of the Care Act, acting as a forum for the exchange of information in relation to provider performance and around areas such as Deprivation of Liberty Safeguards. In 2015/16 it will widen its membership and become the Quality Assurance subgroup of the Safeguarding Adults Board.

Training

- We ran safeguarding training for staff, providers and partners which incorporated the Care Act changes and Making Safeguarding Personal principles. We ran Mental Capacity Act training to staff and providers. We established a regular staff case review forum where staff can discuss complex cases and receive peer and management support.

- The London Fire Brigade provided training to ensure that our staff know when they should be making referrals to the fire services. This should result in an increase of referrals to LFB and hence the increased safety of our service users.

Key challenges

- The key challenges for the Safeguarding Adults Team in 2014/15 have been to manage the huge increase in Deprivation of Liberty Safeguards applications within existing resources, to manage the administrative functions of the Board and be a driving force behind implementation of Making Safeguarding Personal and the Care Act.
- For Adult Social Care, the main challenges have been using the Framework-i new case recording system and preparing for the implementation of the Care Act. These changes have required training and with the Care Act, time spent reflecting on practice.

Priorities and plans for 2015/16:

- We aim to carry out an internal safeguarding audit to fully understand where we are at and to inform improvements in social work practice and recording of activity on Framework-i.
- We plan to offer support to Safeguarding Adults Managers via monthly meetings chaired by a representative from the Safeguarding Adults Team and to consider developing safeguarding "champions" within Adult Social Care.
- We will embed learning from any Safeguarding Adults Reviews into practice via policies, procedures and training; for example, a through implementing a self-neglect protocol. We will also consider expanding the current social work case review forum to include a space for discussion of safeguarding cases/issues, external speakers on issues such as domestic violence, fire safety etc.
- We will carry out a benchmarking/outcomes appraisal regarding Deprivation of Liberty Safeguards in order to learn from other boroughs about options to manage the increasing number of applications for deprivations of liberty; for example, the advantages and disadvantages of having dedicated Deprivation of Liberty Safeguards practitioners.
- We will further develop safeguarding information available on both the intranet and internet.
- We will develop closer links with partners such as the London Fire Brigade and the Domestic Violence team to ensure that we are appropriately referring to other agencies and making full use of the range of services in Hackney.
- A Making Safeguarding Personal staff event is being planned for November 2015.
- An internal audit of safeguarding practice is being planned for October/November 2015 in order to inform future planning for improved safeguarding practice and recording/reporting.

- Further work on the safeguarding adults workflow will continue in 2015/16 in conjunction with other London boroughs to ensure consistency of data recording on outcomes across London.

8.3 Metropolitan Police Service

Overview

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

The London position for safeguarding adults has changed significantly over the last few years. Historically the 32 Boroughs were operating to different policies, procedures, recording and referring processes. None of which were recordable or searchable. The first step towards a joined up approach within the Metropolitan Police Service was the creation of the Service's Safeguarding Adults policy, with a focus on those targeting people who were in receipt of care or a position of trust.

Safeguarding is about partnership work and the creation of Pan London procedures to which the Metropolitan Police Service has signed up demonstrates our commitment with others to work together.

The lead for the National Association of Chief Police Officers (Gary Cann) has announced the imminent launch of the first National Investigative Guidance for police to Safeguard Adults. The Metropolitan Police Service contributed significantly to this document which will help shape the structure for more effective safeguarding investigations.

Following on from the review into Winterbourne View highlighted in the Panorama programme amongst the many recommendations there was one for police – to look at how we can identify patterns of abuse and escalation. The upgrade of the Merlin system will go a long way for the Metropolitan Police Service to achieve this.

Allegations of crime involving a Vulnerable Adult where abuse, neglect or ill treatment is alleged are now managed by experienced investigators within the Community Safety Unit. These officers have received enhanced training to reduce the impact of the investigation upon the victim by the use of special measures and intermediaries. (Intermediaries perform an important function, helping the most vulnerable members of our society gain equal access to justice. An intermediary is somebody who can help a vulnerable witness to understand questions they are asked and can help to communicate the witnesses' response. They help the witness at each stage of the Criminal Justice process, from police investigations and interviews, through pre-trial preparation and at court.)

All staff have access to legal services for any complex legal advice required for adult safeguarding cases.

Staff are supported by operational instructions that inform them of their responsibilities under the Mental Capacity Act and they have Strategic Support Units to provide operational support and advice as required on safeguarding and mental health issues.

Safeguarding Activity

- The Metropolitan Police Service define of abuse of a vulnerable adult as: "A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust (which can include a relative, carer or service provider) which causes harm or distress to a vulnerable adult." Between 31st August 2014 and 31st July 2015, 1766 Vulnerable Victims have been identified by officers within 1665 Crime Reports. The breakdown of Vulnerability for the Victim is as follows:

Physical Impediment	294
Intimidated Victim or witness	904
Mental Impediment	456
Not relevant to this victim	47
Victim of knife or gun crime	48
Other	17

- During this reporting period, Metropolitan Police Service Hackney recorded 17 allegations of Carer abuse against an adult for offences including Assault, GBH, Theft, Neglect, Sexual Assault and Rape. These have been investigated by Detectives together with Partner Agencies as appropriate. Outcomes vary as these investigations can be complex in their nature and present with evidential difficulties. The breakdown of Outcomes is as follows:

Charged	1 (GBH)
Suspect unidentified	5
No crime / offences	5
No prosecution resulting	4
Ongoing investigations	2

- From April 2013 the Metropolitan Police Service has recorded encounters with vulnerable adults who came to the attention of police whether as a victim, witness, suspect or member of the public. These encounters are recorded on the MERLIN system as an Adult Coming to Notice in the following circumstances: Where
    a.) there is a concern of vulnerability in one or more of the following aspects:
        1. Physical
        2. Emotional/Psychological
        3. Sexual
        4. Acts of Omission / Neglect
        5. Financial

    and

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

- During the reporting year September 2014 to July 2015 there have been 2609 Adult Coming to Notice Merlins created by officers who have come into contact with a Vulnerable Adult and of these 1696 have been referred to Adult Safeguarding services for intervention. This equates to an increase of 130 % in reports coming in and 300 % increase in shared information on the previous reporting period September 2013 to July 2014, when there were 1180 notices of which 544 were shared. The increase in the number of allegations and referrals made is directly linked to increased awareness as police, employees and society in general become more aware of their safeguarding responsibilities.
- The Metropolitan Police Service also records all incidents under Section 135 and 136 Mental Health Act 1983 as Adult Coming to Notice reports. Non-Section 135/6 reports will be reviewed and researched by the Multi-Agency Safeguarding Hub to identify risk and cases which require a referral to an appropriate agency for intervention. The number of Adult Coming to Notice reports received by Hackney Hub fluctuates but daily reporting levels are at about 15 each day at present.

Key Developments

- Formal policies, procedures and expectations are now in place to ensure a corporate response by the Metropolitan Police Service that consolidates its work with people who experience or may be at risk of abuse and neglect.
- Dedicated staff within the Community Safety Unit to investigate allegations involving vulnerable adults. These officers have been able to develop good links with Adult Safeguarding for better investigations and attendance at Strategy meetings.

- Following a critical incident review, Metropolitan Police Service Hackney has undertaken a review of partnership working with Hackney Mental Health hospitals and the Multi Agency Public Protection Arrangements process. This has resulted in an increase of hospital referrals to Level 2 Protection Arrangements meetings, enabling an improved response to risk management and intervention.

Training

- Since January 2014, all frontline staff received mandatory training on the 'Vulnerability Assessment Framework'. This is currently being rolled out across the MPS and will therefore be measurable for compliance.
- The roll out of training has resulted in increased awareness by front line staff around adults at risk and this has led to a significant increase in Adult Coming to Notice merlin reports and referrals.
- Police officers and staff are not medical professionals. Therefore officers are being trained to identify those adults who are vulnerable and which referral pathways they can use to support them.

8.4 Homerton University Hospital NHS Foundation Trust

Overview

The Homerton University Hospital NHS Foundation Trust (HUHFT) is committed to safeguarding adults at risk of harm or abuse. Two of the Trust's four values are particularly key to the approach that the Trust has worked towards embedding in 2014/2015:

- Safe: we will do everything we can to make our services as safe as possible and create a positive learning environment, and
- Personal: We will provide care which addresses individual needs and focuses on our patients, service users, their families and carers, and our staff.

Much of the safeguarding work undertaken during 2014/2015 was in preparation for the implementation of the Care Act 2014 and in responding to the Supreme Court 'Cheshire West' ruling on deprivations of liberty in care settings (see Appendix 2 for more information). The management of residents at Mary Seacole Nursing Home, which is run by the Trust, has been reviewed in light of the ruling.

The sections below provide a brief summary of safeguarding activity particularly at Trust-wide level. The Trust's Safeguarding Adults Annual Report 2014/15 will be presented to the Trust Board in September 2015 and will contain more detail of how the Trust has performed in relation to its safeguarding adults priorities.

Safeguarding Activity

Work of the Trust Board in scrutinising safeguarding adults

- The Trust Board scrutinises how the organisation helps to safeguard adults at risk in the communities it serves through a variety of mechanisms. The Executive lead for safeguarding (adults and children) is the Chief Nurse and Director of Governance who also provides the key link between HUHFT and City and Hackney Safeguarding Adults Board partners.
- The Integrated Quality report discussed and approved at the monthly HUHFT Board meeting includes a number of indicators and information relevant to safeguarding adults. For example, a measure of 'harm free' care used in the NHS called the Safety Thermometer provides a 'temperature check' on harm. The Safety Thermometer is a point of care survey carried out on 100% of patients on one day each month. The indicators measured include, pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (blood clots). These factors are some of the key indicators used by the Trust Board to measure and monitor the safety of care for patients and clients, many of who will be adults at risk. This initiative can serve as an early warning of the Trust's services causing harm to patients or being at risk of failing to deliver harm free care.
- During 2014/2015, HUHFT had consistently high rates of harm free care (above the national average of 94%) with relatively low rates of hospital acquired pressure ulcers when compared to the national average. The level of falls was also lower than the national average for 10 out of 12 months.
- The Board also receives the Safeguarding Adults Annual Report in September.

Homerton Safeguarding Adults Committee

- The Chief Nurse chairs the Homerton Safeguarding Adults Committee which met three times in 2014/2015. The committee provides a forum for staff across the organisation and colleagues from partner organisations such as London Borough of Hackney to examine strategic issues as well as safeguarding performance.

Performance against the Safeguarding Adults at Risk Audit Tool

- The Trust has used the Safeguarding Adults at Risk Audit tool developed by NHS England to help develop the safeguarding adults work plan. The Trust was commended by NHS England (London) for its approach to this audit tool. Gaps in performance related to safeguarding adult team staffing, scrutiny of services commissioned or contracted by the Trust, engagement with the Government's *Prevent* strategy and the systematic collection of data on safeguarding incidents. All improved between June and October 2014, when the Audit tool was revisited.

Safeguarding adult disclosures and Deprivation of Liberty Safeguards applications

- Almost 170 disclosures or incidents were reported by Trust staff as related to adult safeguarding. Initial analysis suggests that the top three harms were neglect (including self-neglect), physical abuse and emotional/psychological abuse. The rise in the number of incidents related to neglect compared with 2013/2014, is marked, but at this stage is difficult to tell whether this is a result of raised awareness and reporting, or due to difficulties in organisations supporting adults at risk with care needs.
- The Supreme Court 'Cheshire West' ruling on deprivations of liberty (see Appendix 2) in has meant that the number of applications for Deprivation of Liberty Safeguards authorisation has increased in 2014/15 compared with 2013/2014. For example, there was a seven fold increase in the number of applications in quarter 2 compared with quarter 1 in 2014/2015. Knowledge, understanding and systems to help staff care for patients who are under continuous supervision and control, are not free to leave their care setting, and lack capacity to consent to these things are also continuing priorities within the 2015/2016 safeguarding adults work plan.

Key Developments

Participation in multi-agency partnerships

- HUHFT has been an active participant in regional (North East and Central London Safeguarding Adults and Prevent network) and local (CHSAB executive and sub-groups). In addition, both children and adult safeguarding leads have participated in the Hackney Prevent partnership. HUHFT benefited from a London Borough of Hackney senior staff briefing on the Care Act, which came into effect in April 2015.

Improved joint working between safeguarding children and safeguarding adults committees building on shared principles

- Joint working between the Children Safeguarding and Regulation Committee and the Homerton Safeguarding Adults Committee was taken forward during 2014/2015 via joint meetings of the committees. The first joint meeting of the committees in February 2015 built on the shared safeguarding principles which were identified in a facilitated joint workshop in October 2013. In addition, the Homerton Safeguarding Adults Committee met three times during 2014/2015 to shape and monitor safeguarding adults activities.

Increased central safeguarding team capacity

- The central staff team resources dedicated to safeguarding adults improved with the successful recruitment and appointment of a Lead for Safeguarding Adults from end of July 2014 to April 2015. This has enabled support to be provided to clinical staff, particularly with respect to complex safeguarding cases. It also resulted in direct support to specific adults at risk and their families or carers.

Improved safeguarding adults training to develop competence and confidence

- The content of training for staff on safeguarding adults was revised with the introduction of case studies tailored to specific staff groups and care settings in order to stimulate discussion and reflection. These sessions have been run since November 2014.

Training

- Safeguarding Adult Level 1 training is mandatory and is provided to all staff when they start work at the HUHFT. There is also a statutory annual update for all staff via the Trust Statutory and Mandatory Training booklet. There are high levels of participation in level 1 training and these levels are reported to the Trust Board each month. Between April 2014 and March 2015, the average participation rate in adult safeguarding was 95.6%.

Figure 8: Mandatory training data (HUHFT)

Source: HUHFT

Homerton University Hospital NHS

BOARD REPORT | WELL LED | MANDATORY TRAINING

Indicator	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
Basic Life Support	72%	68%	69%	72%	72%	71%	57%	63%	66%	64%	61%	62%	65%	71%	75%
Blood Transfusion	68%	81%	87%	80%	-	72%	81%	80%	81%	79%	84%	84%	83%	79%	79%
Child Protection	95%	94%	94%	96%	96%	96%	94%	97%	92%	90%	92%	92%	93%	95%	94%
Conflict Resolution	96%	95%	95%	96%	94%	94%	95%	90%	92%	92%	93%	91%	92%	92%	93%
Equality and Diversity	96%	95%	95%	96%	95%	95%	86%	82%	89%	87%	86%	84%	86%	89%	89%
Fire	67%	69%	69%	71%	69%	67%	60%	54%	58%	57%	55%	63%	76%	85%	86%
Health & Safety (Object Handling)	96%	94%	95%	96%	94%	94%	95%	90%	92%	90%	89%	91%	92%	93%	93%
Infection Control	94%	93%	94%	96%	94%	93%	89%	89%	98%	90%	88%	89%	90%	91%	92%
Information Governance	58%	51%	53%	58%	53%	52%	47%	46%	44%	39%	36%	58%	75%	86%	86%
Patient Handling	77%	77%	78%	79%	78%	78%	80%	84%	75%	78%	78%	77%	82%	86%	86%
Safeguarding Adults	97%	96%	96%	97%	100%	100%	100%	94%	92%	90%	95%	94%	95%	95%	95%

- Safeguarding adult training at level 2 and level 3 was also provided mainly for clinical staff working with adults at risk.

Priorities and Plans for 2015/16

Tailoring services to individual needs and characteristics and are outcome focussed

- Developing systems to capture and respond to the personalisation elements of the 6 principles of safeguarding adults in the Care Act. Examples include developing a safeguarding specific module on the HUHFT incident reporting system in order to enable and encourage staff to ask and record what the adult at risk views on the outcomes from the safeguarding process should be so that these views directly inform what happens.
- Using analysis of safeguarding incidents and disclosures to develop bespoke training sessions for specific staff groups and services in order to support staff in delivering improved outcomes for patients.
- Strengthening joint working with specialists in dementia, learning disability, end-of life care, falls, pressure ulcers and 'hidden harms' such as substance misuse.

Leadership and organisational culture

- Improve the capacity of the safeguarding adult team via the recruitment of a Safeguarding Adult Practitioner. This role will focus on developing a comprehensive safeguarding adults training plan as well as building a network of Safeguarding Adult Advisors to provide peer support to their colleagues on safeguarding adults and assisting clinical staff with complex case work.
- Develop e-learning modules for safeguarding adults training at level 2, to help increase levels of participation in safeguarding adults training as well as levels of competence.
- Develop bespoke topic focussed training in matters such as mental capacity and DoLS.

Governance and multi-agency working

- Develop a communication plan so that policy and other developments relevant to safeguarding adults and key contacts are easily accessible to staff.
- Devise a process for capturing learning and action arising from multi-agency working and ensuring this is disseminated to key staff

Responsibilities towards adults at risk are clear for all staff

- Revise policies and procedures relevant to safeguarding adults in light of the Care Act 2014 and the implementation of the Health and Social Care Act 2008 (amended 2015) Fundamental Standards.
- Develop an audit programme to test and measure implementation of safeguarding adults policies and outcomes for adults at risk and their families/carers.

8.5 Probation Service

Overview

The mission of the National Probation Service is "Preventing Victims by changing Lives". The role of the NPS is to protect the public, support victims and reduce re-offending which includes working in partnership with service providers, partners and the community. The NPS will deliver the best possible service to the public, enforcing the sentence of the court and working together with partners, communities and with those offenders under supervision to change their lives through reform, rehabilitation and reparation to help build safer communities.

Safeguarding Activity

- Delivery of Safeguarding Adults briefings to staff in 2014.
- Management oversight regarding the embedding of good practice safeguarding principles.

Key Developments

- Contribution to the composition of City and Hackney Adult Safeguarding Strategy.

Training

- Delivery of training / briefings to ensure that The Care Act (2014) is understood by staff and implemented.

Priorities and Plans for 2015/16

- Stabilisation of the National Probation Service and CRC's
- Service Delivery for the National Probation Service.

8.6 London Fire Brigade

Overview

The organisation is committed to safeguarding adults, children and promoting wellbeing. This is explicitly reflected in the organisation's mission statement /guiding principles as well as in strategic documents such as the London Fire Brigade's Integrated Risk Management Plan, the 'London Safety Strategic Plan'.

The organisation recognises safeguarding as integral to quality, best practice and working in partnership and the Brigade's ongoing commitment to safeguarding is demonstrated in the Community Safety Committee report number 2359: *Safeguarding, an update on Brigade activity* (18th November 2014).

This commitment is reflected in the level of participation the organisation takes in actively supporting the Board in taking actions within the context of its business plan. All 33 Borough Commanders are non-statutory members of their local Safeguarding Adults Boards. Each Commander reports any adult safeguarding concerns through their SAB and engages in multi-agency partnerships as appropriate. Any learning is shared by the Commander within the Brigade.

The Brigade has a system for reviewing alerts and concerns which is integrated with complaints and serious incident reviews.

The Brigade provides an open, honest and safe environment for all staff and ensures that this is upheld at all times. There is a Whistleblowing policy in place to encourage and enable employees to raise serious concerns within the Authority.

Safeguarding Adult Activity

- The Brigade is able to evidence how it is implementing the strategic aims of the Board's safeguarding strategy by recording and monitoring safeguarding concerns raised by its services.
- There are specific organisational Safeguarding Adults and Safeguarding Children policies and procedures in place reflecting the organisation's responsibility to safeguard and promote the wellbeing of adults at risk. They include clear lines of accountability, from an individual employee up to the most senior person within the organisation and reference to the importance of keeping accurate records, as well as guidance to support staff in this.
- Disclosure & Barring, Equalities and Sharing Information policies are also in place and support Safeguarding Adults activity.
- The Deputy Manager of Community Safety is the Brigade's Safeguarding Lead and is a member of the London Safeguarding Children's Board.
- A representative of the Community Safety Human Behaviours Team sits on the London Safeguarding Adult's Network as well as the project group for the review of the Pan London Multi-agency safeguarding policy and procedures.
- Connections are made at all levels between related issues where relevant. For instance, the fire retardant nightwear pilot has been put in place as part of our prevention strategy and is aimed at vulnerable adults and those most at risk who may be affected by smoking in bed.

Key Developments

- Work is underway to update data transfer methods which include a new web based concern form. This will provide a more secure and efficient method of data collection and record keeping. Using the new system will also make it easier to identify pan London safeguarding trends and those individuals who have been previously referred.
- The introduction of Egress Switch within the Brigade to staff groups that are required to raise concerns with Social Services departments.

Training

- Operational staff and frontline Community Safety staff, including youth engagements teams receive training on Safeguarding Children and Safeguarding Adults at Risk
- Operational staff are required to refresh their knowledge of both polices annually. The policies are available to all staff on the Brigade intranet.
- All staff receive Equality and Diversity training.
- The staff induction process encourages employees to familiarise themselves with important policies, including Safeguarding.
- To ensure the borough commanders and other key officers are kept up to date with changes in legislation the organisation is holding 'Safeguarding briefing sessions' with an external speaker from London Safeguarding Adults Network to highlight key changes.

Priorities and Plans for 2015/16

- Safeguarding policies are currently being reviewed to take into account the changes in safeguarding with regard to the Care Act (2014).
- To complete work to update data transfer methods to provide a more secure and efficient method of data collection and record keeping.
- The new system will help to identify safeguarding trends pan London and those individuals who have been previously referred.
- To ensure continual improvement the Brigade is in the process of developing a new safeguarding training package which will be rolled out to all staff in 2015.

8.7 East London Foundation Trust

Overview

The Trust offers services to some of the most vulnerable and marginalised people in society and our reporting of safeguarding concerns reflect this.

The Trust holds a bi-monthly Safeguarding Adults Committee meeting attended by representatives from all Trust services. This Committee oversees the strategic agenda, including production of the self-assessment required for the Clinical Commissioning Group, an Annual Report and Work plan for the year. The Head of Safeguarding Adults for the London Borough of Hackney is invited to this meeting and receives all papers.
The Associate Director for Safeguarding Adults & Domestic Abuse has been in post for six years and provides training across the Trust at all three levels of adult safeguarding awareness, the compilation of internal safeguarding reports and case audits, and continues to give safeguarding advice to staff.

Safeguarding Activity

- Trust staff report safeguarding adults concerns that occur within Trust services via the Datix reporting system. These are then responded to via the Trust Assurance team which require a full assessment and outcome to these concerns. Amongst other concerns, there are regular reporting of pressure ulcer incidence, restraint practices resulting in injury and all allegations about staff members or other people using the services. Information is then provided in a quarterly report for scrutiny.

Key Developments

- The NHS England Self-Assessment identified four Amber ratings, which have been addressed throughout the year. All other Ratings were assessed as Green with no Red scores. Full details of this were published within the in Trust Annual Report.
- The Trust has been successful in their bid for the provision of mental health services in Luton and Bedfordshire, meaning the Trust will have adult safeguarding responsibilities across more services.

Training

- In July 2014 the Trust commissioned level 2 training on completing mental capacity assessments for patients over decisions for treatment and on safety in relationships. This was an innovative, customised course using actor-based scenarios that was well received by staff from across all Trust services.
- The Level 1 Awareness training was delivered to all staff at Induction and on site for teams, if required.

Priorities and Plans for 2015/16

- To undertake an Independent Case Audit
- To deliver a Routine Enquiry for domestic violence training programme

- To review and amalgamate the reporting requirements for the Clinical Commissioning Group, the Trust and Local authorities
- To assimilate the new safeguarding adults team from the new Luton and Bedfordshire services within Trust services

8.8 City and Hackney Clinical Commissioning Group

Overview

The City and Hackney Clinical Commissioning Group have maintained ongoing attendance to the Board through their GP clinical lead for adult safeguarding. Throughout the period we have been keen to support developing the subgroups and the preparation for the increased challenges of the incoming Care Act (2014).

We have maintained safeguarding as an important activity and have continued to monitor and respond to concerns raised. Currently have seen minimal numbers reported, although it is recognised that this is likely to increase as awareness develops.

The Clinical Commissioning Group has maintained our own quarterly safeguarding meetings where we review overall safeguarding activity and responsibilities and during this time it has been recognised that the focus and resource has needed to change in preparation for changes to our statutory responsibilities.

Safeguarding Activity

- Our Group Adult Safeguarding policy was re-written by our previous safeguarding GP lead.
- Ongoing interaction and liaison with London Borough of Hackney safeguarding representatives, investigating concerns over provider performance.
- Ongoing interaction with the North and East London Commissioning Support Unit Continuing Healthcare Manager who also has oversight for our local care homes.
- Ongoing provision of a GP adult safeguarding lead, providing support and guidance to Group staff and local GPs.
- Successful joint bid with Tower Hamlets and Newham Groups for £108k to fund a Mental Capacity Act advisor project.
- Completion of the NHS England audit toolkit
- Maintained awareness of NHS England updates through national webinars
- Ongoing clinical quality review meetings continue with the Homerton University Hospital NHS Foundation Trust, focussing on specific commissioning areas to ensure the full range of commissioning activities are covered throughout the year.

- Regular serious incident panels continue to be held.

Key Developments

- Recognition of the need to recruit additional resource to support the growing adults safeguarding agenda.
- Our local 'out of hours' provider is a social enterprise resourced predominantly by local GPs, providing enhanced continuity of care and local knowledge and, therefore, with an expectation that safeguarding should be better managed.
- Our practices have also formed a GP Confederation to provide services to their patients. The Group commissions many of these services and again has high expectations in respect to quality and safety.
- A particular area of focus is the work with the Homerton on pressures ulcers both in the hospital and community. Whilst the overarching aim is to reduce the numbers of ulcers, initially the focus is to increase awareness and therefore the number of alerts that are raised.

Training

- Safeguarding clinical lead attended educational and professional development sessions run through the Board for all partners.
- Local GPs have received additional adults safeguarding training provided by our GP Clinical Lead, held across a number of dates to ensure good attendance.
- Our GP Clinical Lead has also undertaken some additional training with our local 'out of hours' provider, the City & Hackney Urgent Healthcare Social Enterprise.
- As commissioners, basic training is required for all Group staff at varying levels. Many of our staff have received basic level 1 training and this is under review to ensure all staff receive training in 2015-16 appropriate to their role.

Priorities and Plans for 2015/16

- With the recruitment of a new safeguarding lead and the additional time available, we will be looking to ensure a balance of proactive and reactive activities are undertaken. The role of the Designated Adult Safeguarding Manager will also be undertaken by the new resource.
- A training needs analysis to be undertaken for Group staff to ensure appropriate levels of training are maintained and delivered.
- To review of the current adult safeguarding policy to ensure any required amendments are updated.
- Completion of the Group's Adults handbook, ensuring there is easy access available to pragmatic guidance.
- Provider contracts compliance – to undertake reviews and audits to ensure providers are adhering to their contractual obligations in respect to safeguarding.

- In addition to attending the Board, increased support and attendance of the Board's subgroups.
- Ongoing attendance at London safeguarding groups in order to obtain best practice and guidance.
- With the recruitment of a new safeguarding lead and the additional time available, we will be looking to ensure a balance of proactive and reactive activities are undertaken.
- Improved collaborative working with key stakeholders – London Borough of Hackney, NHS England and other Clinical Commissioning Groups. This should result in improved awareness of emerging guidance and information.

8.9 Barts Health NHS Trust

Overview

We are, and always have been, fully committed to ensuring the safety and welfare of every one of our patients across all our sites and services and a number of measures have now been put in place to strengthen the leadership teams and quality of care in our hospitals. Our partners in health and social care have been fully involved in helping us to accelerate positive change which includes the work we will undertake to ensure we protect the rights of vulnerable people who use our services.

Two aspects of the safeguarding agenda, the *Prevent* Strategy and Deprivation of Liberty Safeguards, have grown significantly during the last year. As the main healthcare provider for three of the highest risk boroughs in the country, we are a member of the North East London *Prevent* Network and engaging with the *Prevent* network is a key priority for the Trust.

Care Quality Commission Inspection and Safeguarding

The Bart's Health NHS Trust was placed into special measures by the NHS Trust Development Authority in March 2015 as a result the Care Quality Commission's report from their inspections at Whipps Cross Hospital in November 2014 and January 2015.
The Care Quality Commission undertook an extensive inspection of services across the Trust throughout November 2013. One key recommendation of high importance to the safeguarding agenda is that the Trust should improve in how it listens to staff and responds to their concerns. The key actions are to:

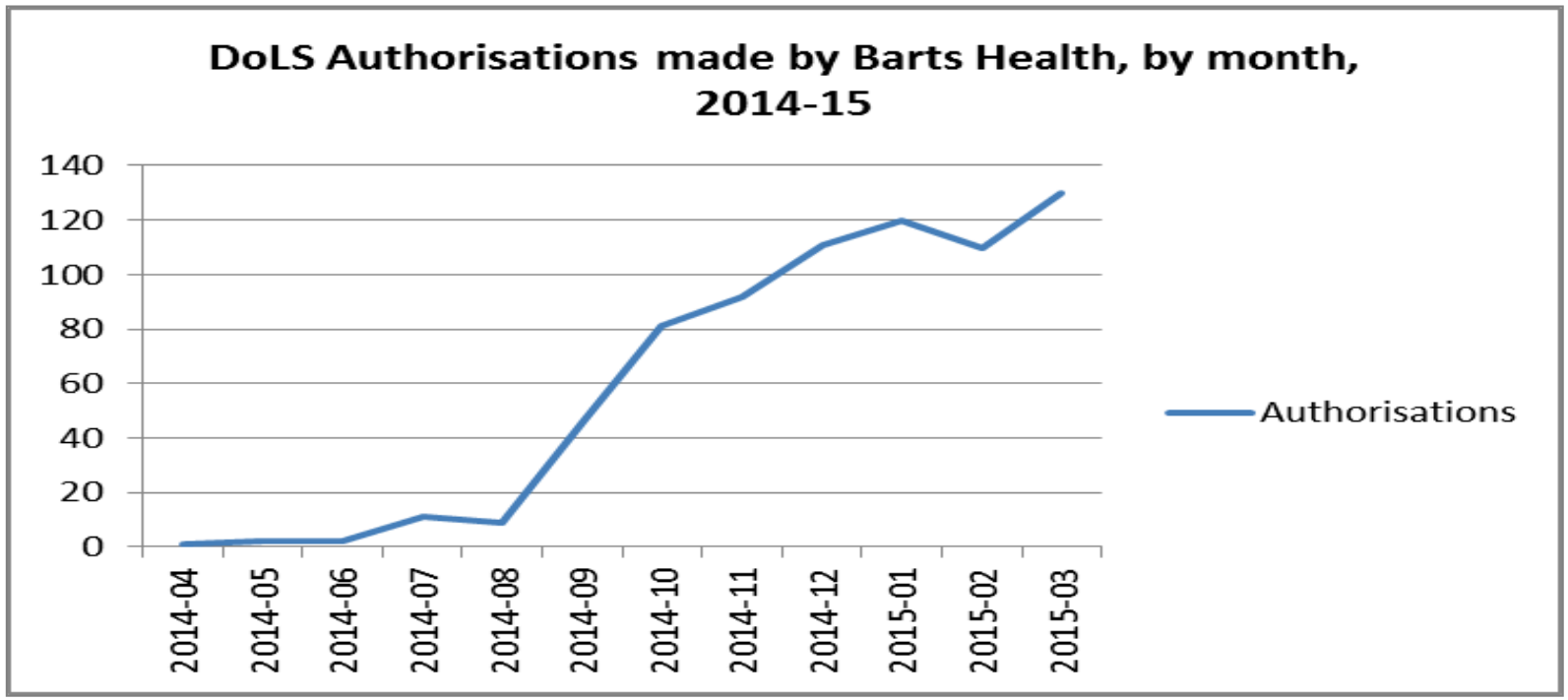
- Reaffirm that bullying and harassment has no place in the organisation.
- Provide an anonymous web based tool for staff to use to contact a director personally for help, advice or to raise concerns.
- Extend the staff partnership forum to improve engagement and hear staff views from across the Trust.
- Commission independent research to investigate and understands staff experiences in the workplace.

- Promote a safety culture in particular the visibility of managers. This includes the appointment of Hospital Director, Hospital Matron and medical equivalent working in alignment with Clinical Academic Group leads, with greater involvement of executives in the work of clinical areas and increased executive visibility on all sites at the weekends.

Safeguarding Activity

- We have been working with our commissioners to develop a single dashboard of metrics for safeguarding that is to be used by health organisations to report performance to Safeguarding Adults Boards and regulators, which is now in final draft.
- The Trust reports on the numbers, themes and outcomes of safeguarding enquiries within the organisation and externally to partners and regulators.
- The internal structure for providing assurance is supported by a safeguarding operational group that reports to an assurance committee. The assurance committee is chaired by the deputy chief nurse and is a subgroup of the Trust's Board. We are reviewing the effectiveness of both these groups in order to strengthen the assurances received from clinical services reporting to the committee.
- The safeguarding adults and children's teams produce an annual report which is reviewed by the Trust Board and, in addition, this year we delivered a seminar to the Trust Board to inform them about the expanding safeguarding agenda.
- There has been a substantial increase in the number of safeguarding incidents reported by and about services at the Trust during 2014/15. This is likely to be a consequence of increased knowledge and awareness of adult safeguarding across the Trust and the improved reporting system we put in place last year.
- Only a small number of enquiries made about safeguarding concerns for patients in our care were found to require further action. However, the timelines for the completion of investigations continued to be challenge.
- Two themes arising from substantiated safeguarding enquiries were: the quality of discharge from hospital and concerns about care whilst using hospital transport. These aspects of care are the focus of ongoing improvement work.
- The learning from investigations is shared through the patient safety team learning from incidents bulletin and the services' governance structures. However, developing a more robust system for learning from safeguarding enquires will be a focus for the Trust this year.
- We have begun focused improvement work with our partners who provide patient transport for our patients.
- We have worked with expert nurses and others to reduce the incidence of pressure injuries across the health economy in North East London as well as improving the reporting of safeguarding concerns in relation to this
- Safeguarding concerns, Mental Capacity Act and Deprivation of Liberty Safeguards are key aspects of care that are raised and discussed at the daily 'safety huddles', attended by sisters and charge nurses at each of the hospitals. This provides an opportunity to share and learn from practice, challenge each other and support staff in improving care.
- We have contributed to the SAB development in response to the care act and are contributing to a wider programme of quality improvement in patient experience across the Trust, which incorporates greater focus on person centred individualised care.

Figure 9: Deprivation of Liberty Safeguards of Authorisations, by month, 2014-15
Source: Barts Health NHS Trust



Key Developments

- We have commissioned a review, to be undertaken by external experts, of our policies and procedures, capacity resource and training strategy. The findings will provide the framework for a safeguarding summit that will involve partners and stakeholders in the development of our model for safeguarding across the Trust.
- This year we have worked with carers to co-produce a Carers policy which was launched during Carers Week in May 2015.
- We have appointed a lead for Mental Capacity Act, Deprivation of Liberty Safeguards, *Prevent* and Mental Health and over the last year we undertook a range activty to ensure we are compliant and that our patients are protected. The impact of this work can be seen in the steep increase in the number of Deprivation of Liberty Safeguards applications made in the Trust over the last year (see Figure 8).

- Developed detailed guidance, flowcharts and decision-making aids which are available to all staff together with electronic information and resources.
- Liaised with partner organisations locally to ensure a cohesive approach.
- Developed streamlined systems for making, submitting, recording, monitoring and following up Deprivation of Liberty Safeguards applications in line with statutory requirements.
- Worked intensively with staff in all hospitals, particularly in services treating a large number of patients without capacity, to promote the appropriate use of Deprivation of Liberty Safeguards authorisations.

Training

- The principles of the *Prevent* strategy are included in our Safeguarding Adults policy and mandatory training. Training implementation did not progress further during the year because of the Home Office's withdrawal of an approved training package for the Strategy. However, new training is now available and the national leads for *Prevent* within NHS England will be providing training to 20 leaders across the Trust in the coming year.
- Developed a range of training packages covering the practical aspects of Deprivation of Liberty Safeguards compliance, and updated material relating to Deprivation of Liberty Safeguards in our statutory and mandatory training booklets.
- Delivered face to face training on Mental Capacity Act and Deprivation of Liberty Safeguards to 578 clinical and management staff, through one to one coaching, ward-based teaching, whole service events and open access sessions.
- Commissioned high level expert training through our partner mental health organisations. Members of our safeguarding team undertook this training in September 2014.

Priorities and Plans for 2015/16

- Developing a training strategy that will include provision for enhanced safeguarding adults training for senior leaders.
- Embedding the principles of protecting adults at risk from harm. The first step in this process will be to hold a safeguarding summit at Whipps Cross Hospital, engaging national expertise and leaders to inspire and engage our staff in this essential area of healthcare work.
- Consolidating and extending the work that has been done this year in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards, and, in particular, developing and implementing procedures to ensure that mental capacity is formally assessed and recorded for all patients where the patient is suffering from conditions which may compromise their ability to consent to their admission and treatment.

9 Key Contacts

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

For London Borough of Hackney:

You can contact Hackney Council's Safeguarding Adults Team directly on:

Tel: **020 8356 5782** Outside office hours tel: **020 8356 2300**
Email: **adultprotection@hackney.gov.uk**

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

For City of London:

You can contact the City of London's Adult Social Care Team directly on:
Tel: 0207 332 1224 Outside office hours Tel: 020 8356 2300
Email: social.services@cityoflondon.gov.uk

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

For the City & Hackney Safeguarding Adults Board:

Tel: **020 8356 7338**
Email: **CHSAB@hackney.gov.uk**
http://www.hackney.gov.uk/safeguarding-adults-board.htm#.Vgn-pEtbHHg

Appendix 1

Membership of the City & Hackney Safeguarding Adults Board 2014-2015

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

Appendix 2

'Cheshire West' and deprivations of liberty

A person's care arrangements should always promote their independence and be in their best interests. The arrangements should be as least restrictive of the person's rights and freedoms as possible. The care arrangements of many people living in different situations can deprive those individuals of their liberty when they do not have the capacity to consent to this. Such deprivations of liberty can be entirely appropriate and in the person's best interests, but they need to be decided lawfully with the right checks and balances in place. However, there has been no single legal definition of a 'deprivation of liberty', so it can be difficult sometimes to work out if one is taking place in a person's care arrangements. On 19 March 2014, the Supreme Court handed down its judgment in the case of *P v Cheshire West and Chester Council and another* and *P and Q v Surrey County Council*. These judgements have become known collectively as 'Cheshire West'. They set out set out what determined if a person was being deprived of their liberty for the purposes of receiving care and treatment. This has become known as the 'acid test'.[5] It asks if the person, who does not have the capacity to consent to their care arrangements, is both:

1) **subject to continuous supervision and control**
   and
2) **not free to leave**

If the person is subject to *both*, and for a '**non-negligible' period of time**, then they are being deprived of their liberty and this should be lawfully authorised. A deprivation of liberty in such a situation must be authorised in accordance with one of the following legal regimes: a deprivation of liberty authorisation or Court of Protection order under the Mental Capacity Act Deprivation of Liberty Safeguards, or (if applicable) under the Mental Health Act 1983, or, in some rare situations, under the inherent jurisdiction of the High Court.

The reason for the deprivation, the relative normality or quality of the person's care setting and whether the person agrees or objects to their deprivation, are all irrelevant to first considering if a deprivation of liberty is taking place or not. If there is a *risk* of a deprivation of liberty, then further assessment must be undertaken to determine this.

The Cheshire West judgment has, therefore, been important for deciding whether arrangements made for the care and/or treatment of an individual who might lack capacity to consent to those arrangements amount to a deprivation of their liberty. In effect, the 'acid test' has widened and clarified what a deprivation of liberty for such a person is. This means that, legally speaking, many more people's proper and suitable care arrangements may be depriving them of their liberty. The result of this is

[5] *P v Cheshire West and Chester Council; P & Q v Surrey County Council [2014] UKSC 19, 48*

that the number of applications to local authorities to authorise the deprivation of liberty of individuals residing in care homes and hospitals (under the current Deprivations of Liberty Safeguards regulations) have increased significantly. This has affected the workload, resource capacity and safeguarding activity of a number of the Board's partners.

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