SAFEGUARDING ADULTS EXECUTIVE BOARD

ANNUAL REPORT 2014/15

METROPOLITAN POLICE
TOTAL POLICING

NHS

h&f
hammersmith & fulham

THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

City of Westminster

SAFEGUARDING ADULTS EXECUTIVE BOARD

ANNUAL REPORT 2014/15

CONTENTS

FOREWORD

I am pleased to present the second annual report of the Safeguarding Adults Executive Board (SAEB) for Hammersmith & Fulham, Kensington and Chelsea, and Westminster. The report describes how the Board's agencies, both jointly and independently, work to ensure the safety of those people within the boroughs who are deemed to be most at risk of harm through the actions of other people.

The Care Act 2014 which became law on 1 April 2015 prescribes a more wide ranging definition of abuse; one of a number of significant changes contained in the Act.

Section 14 of the statutory guidance outlines how the Act affects Safeguarding Boards. In certain key areas we are already compliant; the SAEB has been in existence for over 2 years and we have compiled and published annual strategies and reports throughout my time as chair.

The Board has made significant progress in setting up its Safeguarding Adults Case Review Group. This group examines all cases involving serious harm to or death of an adult in need of care and support, where agencies might have worked together to prevent abuse or harm. The group makes recommendations to me as an independent chair as to the next steps. For example, they considered the death of an elderly resident at a local care home in November 2014 and I decided to instigate an independently-led safeguarding adults review. The final report will be considered by the Board in December 2015.

However there are important decisions which need to be resolved in the next few months. I have already challenged member agencies to contribute to a Board budget (it currently has no funds so case reviews are reliant upon the generosity of individual members); how each member will meet the requirement for a Designated Safeguarding Manager; and the need to agree and implement information sharing arrangements which are both practical and understood by all staff.

The statistics at the end of the report show the progress achieved against the Board's outcomes framework. It is also important to look at the impact on individuals. The report contains examples of anonymised safeguarding investigations which had different resolutions but all had the active involvement and agreement of the person concerned at each stage of the enquiry. These are examples of the Making Safeguarding Personal (MSP) initiative which is being adopted by all Adult Social Care and Mental Health teams. MSP is a Board priority for 2015/16. Its impact upon safeguarding investigations is discussed by Board members and managers at the annual case study sessions. These informal meetings are well-received by both case managers and Board members, giving an opportunity for increased understanding of the demands and challenges faced by front line staff as well as reflective learning by the practitioner with a Board member.

From our priorities for 2015/16, I would highlight one key area: **obtaining the views of people who use services and their families to support continuous improvement**. This is the remit of the Community Engagement sub-group, one of the four workstreams which help the Board to deliver its work plan. To ensure a wider representation, this group now has two chairs; the safeguarding leads from both MIND and the Peabody Housing Association. The group will be organising a consultation on the Board's strategic priorities for 2015-18 in order find new ways of engaging with our communities and involving new partners in safeguarding activities.

I would like to end by thanking everyone for their contributions to the work of the Board. I am impressed by the commitment shown by all members and their common sense of purpose to ensuring the safety and well-being of residents in need of our care and support.

Mike Howard
Independent Chair of the Safeguarding Adults Executive Board

Safeguarding in action

Mrs. Y is 83 years old and recently moved into a local care home. When she was younger, she suffered from mental illness. A safeguarding concern was raised by her daughter who said that she was concerned about the care her mother received, particularly the amount of time she was spending in bed. She had raised the issues with the care home but was not happy with their response.

A care manager who had known Mrs. Y for some time, made enquiries and found that much of what Mrs. Y's daughter was saying was true. However, the reason Mrs. Y stayed in bed was that she was reluctant to get up, and it took time every day for staff to persuade and encourage her to do so. Mrs. Y has capacity and confirmed this account of events.

At the meeting to discuss what the care manager had found, it was clear that the trust between the home and Mrs. Y's daughter had broken down, so the chair of the meeting focused on what could be done to rebuild this. Mrs. Y's daughter said that the best thing for her mother would be to move to another home. Arrangements were made for Mrs. Y to go and visit another home, but on the day of the visit, Mrs. Y changed her mind. Mrs. Y said that there was nothing left to do with regard to safeguarding.

Her daughter said she would use the home's complaints service if she had other concerns about the quality of care provided.

NATIONAL CONTEXT FOR SAFEGUARDING

The most significant driver for change this year in safeguarding has been the implementation of the **Care Act 2014** which has placed safeguarding adults on a statutory footing. The Act requires local authorities to have in place a Safeguarding Adults Board, with a strategic plan and an annual report on how it is achieving it strategic goals.

The governance arrangements for safeguarding in the three boroughs are sound, with a well-attended Safeguarding Adults Executive Board made up of representatives from the three key agencies; Adult Social Care; the Clinical Commissioning Groups; and the Police, and most agencies working with adults at risk.

The three workstreams of the Board: **Community Engagement**; **Developing Best Practice**; and **Measuring Effectiveness**, are sustained by the work of an even larger group of people committed to progressing the Board's work of preventing abuse and neglect in the three boroughs.

Work is complete on the arrangements for the Board to fulfil the requirement under Section 44 of the Act, to review deaths or incidents of serious harm, where agencies may have worked together more effectively to prevent harm. The Safeguarding Adults Case Review group meets every six weeks and has made its first recommendation, which was accepted by the Chair of the Board, for a Safeguarding Adults Review.

The Act has introduced new categories of abuse: **self-neglect**; **modern-day slavery**; and **domestic abuse**.

> **"The most significant driver for change this year in safeguarding has been the implementation of the Care Act 2014"**

Safeguarding in action

London Fire Brigade have produced a training resource for front-line staff going into people's homes to raise awareness of fire risks, and prevent unnecessary deaths.

There is a simple checklist to disseminate to agencies. Fire training will be included in all contracts of agencies who go into people's homes.

This has sharpened the need for the Board to work more closely with a wider range of partners including the Violence Against Women and Girls strand of Community Safety; and with the Local Children's Safeguarding Board on shared agendas such as mental health; substance use; and domestic abuse; and, with the new responsibilities towards carers under the Act, with young people in transition.

Work around self-neglect and hoarding, has meant strengthening partnership working between health; environmental health; Adult Social Care; housing; and the London Fire Brigade. There is a growing commitment to joint risk assessment, risk management, and planned interventions which are designed to improve people's living arrangements and avoid unnecessary deaths.

To a lesser extent, the Cheshire West judgement on the Deprivation of Liberty Safeguards (DoLS) has been a driver for change, and has placed an almost impossible burden on local authorities to meet their legal responsibilities. The response in the three boroughs has been efficient and practical, with a continuing focus on person-centred Mental Capacity assessment and Best Interests decision-making. This has achieved some good outcomes for people who are deprived of their liberty.

The Law Commission's review of the Mental Capacity Act 2005 and DoLS has been accelerated as a direct result of the unworkability of the Cheshire West judgement, and the DoLS service has been working with the reviewers to shape the review. The Board will be submitting a response to the consultation in October 2015. It is anticipated that a Bill to amend the Mental Capacity Act 2005 will be placed before Parliament in 2016.

Other developments that have impacted on safeguarding are the radical changes to the way the Care Quality Commission regulates and inspects health and social care services with the new rating system which was rolled out in October 2014. The Care Quality Commission is rightly focusing inspections on the experience of people and their families of the care they receive. This has increased the number of homes where care is inadequate or requiring improvement, with the attendant need for more focused monitoring, and joint work, to raise standards of provision for people from the three boroughs. This applies equally to people in receipt of homecare, hospital care, and residential and nursing care; and to people living in the three boroughs, and to those placed in other parts of the country.

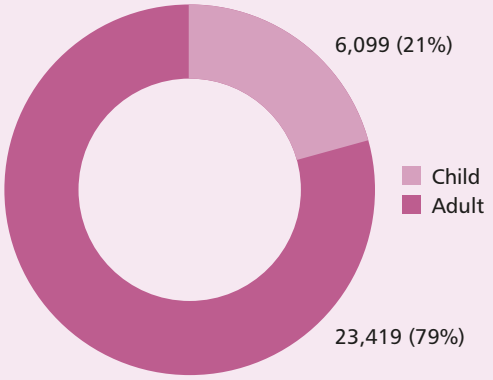
All this is against a backdrop of reduced public service funding which will mainly impact on the local authorities and the police, with attendant restructuring of organisations. This places a greater imperative on the Board, and its member agencies, to find ways of working even more effectively together to ensure that people are directed to the best source of help, first time, every time, making best use of all our assets, and avoiding delays or duplication, or wasted effort.

> **“There is a growing commitment to joint risk assessment, risk management, and planned interventions”**

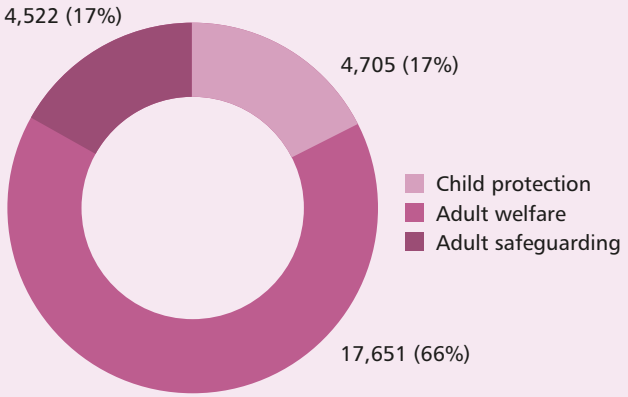
Safeguarding in action

This extract from the London Ambulance Service Safeguarding Annual report 2014-15 illustrates how the service is refining the data it collects and shares, in order to make better decisions about directing people to the agency that can best provide the help they need – in this case, either an assessment of their care and support needs (welfare), or a safeguarding enquiry (adults or children).

Referral by type 2013/14



Referral by type 2014/15



WHAT THE SAFEGUARDING ADULTS EXECUTIVE BOARD IS AND WHAT IT DOES

The Safeguarding Adult Executive Board serves the London Borough of Hammersmith & Fulham; the Royal Borough of Kensington and Chelsea; and the City of Westminster.

The Board represents a partnership of agencies who together work to promote people's right to live in safety, free from abuse and neglect. Its purpose is to ensure that organisations work together to both prevent abuse and neglect, and respond in a way that promotes each person's wellbeing, when they have experienced abuse or neglect.

The Board's strategic role is greater than the sum of the operational duties of its member agencies. It oversees and leads adult safeguarding across the three boroughs. Its task is both to assure the quality of response to those who have experienced abuse and neglect, and to promote practice that prevents abuse and neglect. The Board therefore has an interest in:

- the safety of patients in local health services
- the quality of local care and support services
- the effectiveness of prisons and approved premises in safeguarding offenders
- the work of complementary boards, including the Health and Wellbeing boards; the Local Safeguarding Children's Board; and the Violence Against Women and Children's Board.

The six safeguarding principles

The work of the Board is guided by the six principles that underpin all adult safeguarding work. These are:

Empowerment: People are supported and encouraged to make their own decisions.

Prevention: It is better to take action before harm occurs.

Proportionality: The least intrusive response to the risk presented.

Protection: Support and representation for those in greatest need.

Partnership: Local solutions through services working with their communities.

Accountability: Accountability and transparency in delivering safeguarding.

Courage, Compassion and Accountability

The Board takes the view that preventing abuse and neglect takes three key behaviours.

Adult safeguarding takes **courage**. It takes courage to acknowledge that abuse or neglect is occurring, and it takes courage to overcome our natural reluctance to report abuse and face the consequences for all concerned of having reported it.

The Board encourages members, and people within the organisations they represent, to act with **compassion** towards one another. Compassion, if consistently practised, is most likely to prevent abuse and neglect.

The Board is clear that all member agencies are **accountable** to one another and to the people of the three boroughs whom they serve.

The Board structure

The work of the Board is carried out by its three workstreams: Community Engagement; Developing Best Practice; and Measuring Effectiveness; and the newly formed Safeguarding Adults Case Review group. The Board also commissions time-limited 'task and finish groups' that focus on issues that member agencies identify as needing particular attention.

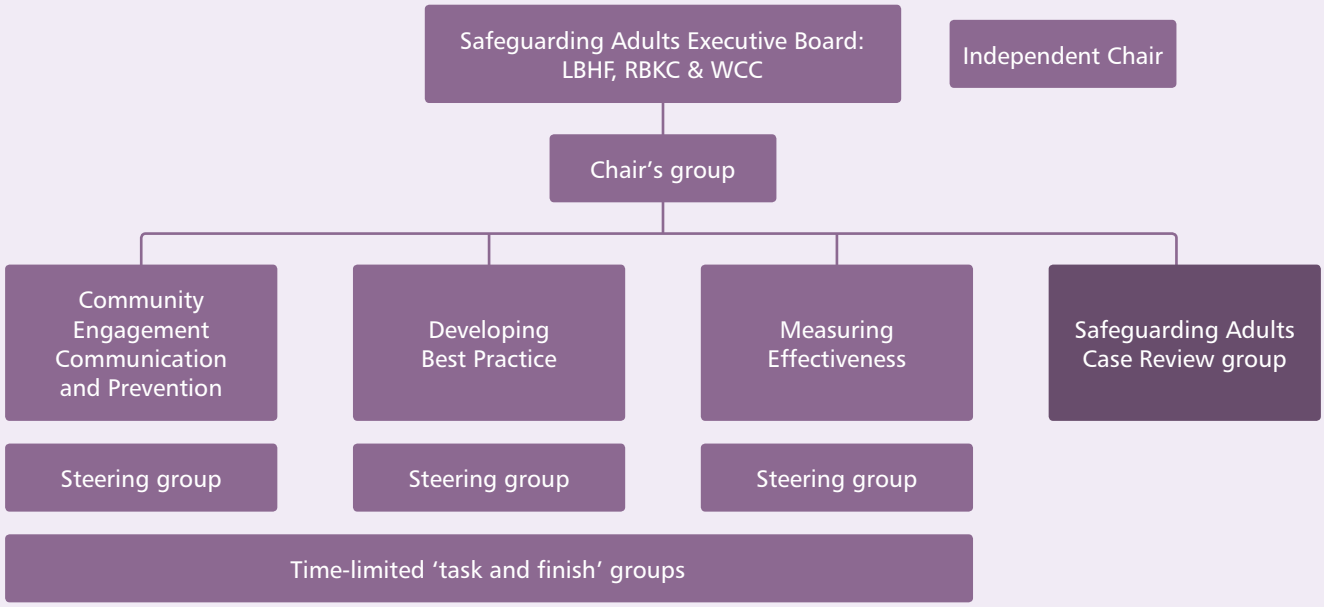
The Community Engagement group raises public awareness of safeguarding and how to act on concerns about abuse and neglect.

The Developing Best Practice group works to increase the effectiveness of staff responses when abuse or neglect has been disclosed.

The Measuring Effectiveness group helps the Board and its members to evidence how its work is making a difference in preventing abuse and neglect of local people.

The Safeguarding Adults Case Review group was developed this year to provide a measured and proportionate response to the Section 42 of the Care Act 2014 requirement to review adult deaths, or serious harm where abuse or neglect may have occurred.

Safeguarding Adults Executive Board



The members

This is a list of the agencies represented on the Board. Members are of sufficient seniority within their organisation to be able to make decisions and commit resources on their behalf. There is an expectation that representatives will attend all four meetings each year.

Agencies represented on the Board

- Adult Social Care
- The Metropolitan Police Service
- CWHHE Clinical Commissioning Groups Collaborative
- Imperial College Healthcare NHS Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Royal Brompton and Harefield NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- Central London Community Healthcare NHS Trust
- Central North West London NHS Foundation Trust
- West London Mental Health NHS Trust
- London Ambulance Service
- Healthwatch Central West London
- London Fire Brigade
- London Probation Service
- Crown Prosecution Service
- Boroughs' Children's Services
- Public Health
- Elected Members from the three Local Authorities
- Community Safety
- Housing
- NHS England
- HMP Wormwood Scrubs

> "The Board's strategic role is greater than the sum of the operational duties of its member agencies"

WHAT WE SET OUT TO DO IN 2014/15

At its meeting in January 2014, the Board adopted five outcomes against which to measure its effectiveness. In order to achieve these outcomes, the Board identified five key areas of work during 2014-2015. These areas were:

- Embedding the **Making Safeguarding Personal**[1] approach into the work of all agencies working with people with care and support needs in the three boroughs.
- Ensuring that the **new statutory duties for Safeguarding Adults under the Care Act 2014** were fully understood, and that Board members were confident about their new responsibilities and about applying them to practice in their organisations from 1 April 2015.
- Developing a **multi-agency process for conducting Safeguarding Adults Reviews**, with capacity and capability to use the Social Care Institute of Excellence's 'Learning Together', as recommended in statutory guidance.
- Learning from Winterbourne View, and consolidating the **joint work of continuously improving people's experience of care**, in care and nursing homes, in their own homes and in the three boroughs.
- Establishing **closer working between the Board and the Local Children's Safeguarding Board; the Community Safety Partnerships; and the Health and Wellbeing Boards**, in all three boroughs, on issues of common concern, to achieve better outcomes for children and people with care and support needs, who have experienced abuse and neglect.

> "In January 2014, the Board adopted five outcomes against which to measure its effectiveness"

[1] See Glossary.

The five outcomes adopted by the Board at its January 2014 meeting:

1. People are aware of safeguarding and know what to do if they have a concern or need for help.
2. People are able to report abuse and are listened to.
3. Concerns about harm or abuse are properly investigated and people can say what they want to happen.
4. People feel and are safer as a result of safeguarding action being taken (but being safe on its own is not enough).
5. The wider well-being of people is maintained or enhanced as result of safeguarding activity.

WHAT WE ACHIEVED IN 2014/15

Understanding the new statutory duties for Safeguarding Adults under the Care Act 2014

Board members were asked to identify their training needs and as a result had the opportunity this year to attend two workshops on understanding the Care Act 2014. These were well-attended and very informative.

In addition, at its meetings, members have been using the Social Care Institute for Excellence (SCIE) checklist to identify areas that need more work in the coming year. These are:

- clarifying the **Designated Safeguarding Adults Manager** role;
- **formalising information-sharing** agreements for Section 42 Enquiries and Section 44 Reviews; and
- committing **resources** to enable the Board to carry out its work.

Members are also mindful that more work needs to be done on involving people who have direct experiences of services, and their families and carers, and organisations that are not represented on the Board, in its work in order to become even more effective. To this end, the Community Engagement group is consulting as widely as possible on the Board's strategy during 2015-16.

Developing a multi-agency process for conducting Safeguarding Adults Reviews

A new sub-group of the Board, the Safeguarding Adults Case Review Group, has been reviewing cases under Section 44 of the Act, where a person has died, or been seriously harmed, and agencies could have worked more effectively to protect the person.

The group is chaired by the Metropolitan Police Borough Commander for Kensington and Chelsea: Agencies represented on the Board are also represented on the group. Additional expertise is provided by Standing Together; a registered manager from a local nursing home; a Trustee of Action Disability Kensington and Chelsea; and the Social Care Institute for Excellence.

The group is working together on **improving information-sharing between organisations**, which is so critical to effective safeguarding. Failure to share information effectively is a repeated theme in national enquiries and Case Reviews. The group's greatest challenges are ensuring that reviews are proportionate to the seriousness of the failure of agencies to work together; and finding the best ways to help families participate in reviews to get answers to their questions, and to help them with their loss.

Joint work of continuously improving people's experience of care

The work of implementing the learning from **Winterbourne View** which was initially overseen by the Board has been carried forward by the Learning Disability Board and the Clinical Commissioning Groups. The work this year has been:

- monitoring the use of assessment and treatment placements for people with learning disabilities
- ensuring people have as little time as needed in assessment and treatment placements
- providing advocates for people with learning disability living outside of the boroughs
- listening to family concerns
- developing local housing provision to, where possible, accommodate people nearer home.

Members of the Board also undertook to review their 'Whistleblowing' policies to ensure staff feel safe when raising concerns.

The managers from nineteen local care homes, together with commissioners and safeguarding adults leads took part in a Health-funded **Compassionate Leadership programme**, ending with a celebratory event on 17 July 2014. The course was well received and well-evaluated.

The impact of the training, and other indicators of quality are tracked through the multi-agency **Safeguarding Information Panel**. Members of the panel share intelligence from contract monitoring; Care Quality Commission reports; safeguarding incidents; placement reviews and identify early signs of concern, and work with providers to take actions to address those concerns and ensure good quality of care.

The work of the Panel contributes to meeting the requirements of the Care Act 2014 to manage the market and prevent provider failure.

Closer working between the Board and the Local Children's Safeguarding Board; the Community Safety Partnerships; and the Health and Wellbeing Boards

The Board has agreed protocols with the **Health and Wellbeing Boards** in each of the three boroughs, so that where safeguarding issues are affecting health outcomes for local people, consideration can be given to how services might be commissioned differently.

Member agencies of the Board contributed to the consultation on the **Violence Against Women and Girls Board** strategy. A protocol about how the two Boards work together is being put in place, to ensure that the new safeguarding categories of abuse under the Care Act, domestic abuse and modern day slavery, are responded to safely and appropriately, making the best use of resources.

In November 2014, the **Local Children's Safeguarding Board** and Safeguarding Adults Executive Board members shared a development event. The event included learning from a national Serious Case Review and identifying areas for joint work. This has led to:

- development of a shared protocol for safeguarding children leaving care
- regular meeting between the Independent Chairs of both Boards
- shared representatives on both Boards
- shared learning from Case Reviews and Domestic Violence Reviews
- completion of the Section 11 audit.

"I have a better work and life balance and I am making the time to listen to my staff and customers. I am more assertive in advocating compassionate leadership and taking individual circumstances into account before making decisions[2]"

[2] From a manager who took part in the Compassionate Leadership course responding to the question: "As a result of the course what changes, if any, have you made in your private life and/or work practices?".

THE FIVE OUTCOMES: WE SAID – WE DID

In January 2014, the Board adopted an outcome focus to its work, in the belief that this approach constantly challenges member agencies to answer the question 'What difference are we making?' This year, we are reporting progress on what we said we would do; WE SAID: WE DID.

In next year's annual report (2015-16), having consulted more widely on the Board's strategic priorities, we will be reporting what YOU SAID: and what WE DID.

OUTCOME 1

WE SAID:

We will make more people aware of safeguarding and what to do if they have a concern or need for help.

WE DID:

The Community Engagement work stream updated the **Keeping Safe leaflet**, helped by the Safeguarding Adults Reference Group[3], to make it meet the requirements of Care Act 2014. The leaflet was distributed to as many organisations as possible and made available electronically on the **People First** website (**www.peoplefirstinfo.org.uk**).

We are now working on a leaflet about **'What to expect after you have raised a concern'** which will be distributed in October 2015.

Twenty organisations, mainly those providing housing and homelessness services, completed the Safeguarding **'Training for Trainers'** course. Trainers train their staff to recognise and report abuse and also make sure that people who use their services know how to raise a concern, and are supported by staff to do so.

Safeguarding in action

The Trust has a training strategy that includes adult safeguarding in mandatory induction and refreshers. The training focuses on responsibility for sharing information about concerns.

Risks associated with the reliance on face-to-face sessions to support staff to fulfill their responsibilities is mitigated by clearly signposted online information including: contact numbers for managerial and local authority support; local services supporting particular risks (e.g. domestic abuse services; channel referrals within PREVENT); applying the Mental Capacity Act; child protection.

Work is underway to ensure that all information and training is in line with the Care Act 2014. One example of this is the Trust's engagement with the development of the Self-Neglect and Hoarding Policy. This was partly prompted by the risks shared by emergency department attendances and the inclusion of self-neglect within the Statutory Guidelines supporting the Care Act 2014.

An extract from the Central London Community Trust's self-assessment as to how it is meeting the Board Outcomes.

[3] The Safeguarding Adults Reference Group is a group of people from who have experience of using services themselves, or represent those who do. Members are trained as adult safeguarding trainers.

OUTCOME 2

WE SAID:

We will make sure people are able to report abuse and are listened to.

WE DID:

We carried out a **Making Safeguarding Personal**[4] pilot in three Adult Social Care operational teams between November 2014 and February 2015.

The pilot confirmed what the customer survey conducted in the spring told us, that:

- people need to have better information about how to report their safeguarding concerns
- people want to be listened to and to be more in control of what happens after they have reported a concern.

The Making Safeguarding Personal pilot encouraged staff to:

- ask the person who has experienced abuse or neglect: 'What do you want to happen next?' at each stage of the safeguarding enquiry
- to consider holding meetings in people's homes, rather than in offices or on wards
- think about whether or not a person needs an advocate.

> **"Staff who participated in the pilot welcomed the approach and it will be rolled out"**

The effectiveness of the work is being measured using Adult Social Care Outcomes Framework national indicators, including 'I feel safer'.

Staff who participated in the pilot welcomed the approach and it will be rolled out across all Adult Social Care and Mental Health teams in the three boroughs in 2015-16.

The effectiveness of the approach from the perspective of people who have experienced neglect or abuse will be measured in 2015-16.

This will be possible, because Adult Social Care has changed its recording to include the outcomes people are looking for. We will be checking and recording at each stage of the safeguarding enquiry if the person who has experienced abuse or neglect is satisfied with their experience.

We will also be conducting another survey of people who have experienced a safeguarding enquiry during 2015-16 to see if Making Safeguarding Personal has made a difference.

Safeguarding in action

We should have involved the person more from the beginning of the case to ask his view of the matter and to explain the situation. We only asked him after we completed much of our investigation and really did not have the evidence to substantiate any financial abuse.

He explained in detail how he provides the person alleged to have caused harm with his bank cards and wallet and tells them to take money. When we learnt this, we were able to have a different, more helpful conversation with him.

Reflection by a Safeguarding Adults Manager on the value of Making Safeguarding Personal.

[4] The Making Safeguarding pilot was sponsored by the Health and Social Care Information Centre; the Association of Directors of Adult Social Services; and the Social Work Research Centre. The pilot has achieved a Gold Standard. This means it was externally evaluated. The validation was provided by Professor Jill Manthorpe from Kings College London.

OUTCOME 3

WE SAID:

Concerns about harm or abuse will be properly investigated and people can say what they want to happen.

WE DID:

We reviewed the system that the police have put in place for **Vulnerable Adults Coming to Notice** to see if a multi-agency safeguarding hub, similar to the arrangements to those for children at risk, needs to be put in place. This work has not been progressed to date because of resource implications for both the local authority and the police.

The Safeguarding Adults Case Review Group is adopting the **Social Care Institute for Excellence 'Learning Together'** model of reviewing the actions taken in response to a concern when reviewing cases under Section 44 of the Act, where a person has died, or been seriously harmed, and agencies could have worked more effectively to protect the person.

As part of Making Safeguarding Personal, and in developing Care Act 2015 Section 42 enquiries, we are working to ensure that the person or agency raising a safeguarding concern is **informed about what will happen next**, by the manager assessing the risks involved. Agencies, including the London Ambulance Service, will be assured that, where appropriate, their raising a concern has resulted in a particular action to reduce the risk to the person involved.

Safeguarding in action

There is a lack of consistency in the Trust being informed about the Local Authority response to safeguarding alerts raised by staff. This limits a robust response to this outcome.

For in-patients, if the safeguarding response is not clearly communicated, any risks are managed within normal multi-disciplinary approaches to care, with the engagement of appropriate agencies engaged with the patient across their pathway of care in the hospital.

Members of trust staff engage in investigations by supporting strategy meetings and case conferences, and by reporting outcomes of investigations where considered appropriate within the case. In cases that involve the care in hospital, investigations commonly are undertaken in parallel with other 'internal' processes; for example, sharing outcomes of Pressure Ulcers Root Cause Analysis, and alongside Human Resource processes if the concerns involve employees of the Trust.

When indicated, staff engage with and support the person at risk to make a meaningful contribution to the safeguarding process.

An extract from the Central London Community Trust's self-assessment as to how it is meeting the Board Outcomes.

> **"Staff engage with and support the person at risk to make a meaningful contribution to the safeguarding process"**

OUTCOME 4

WE SAID:

We want people to feel and be safer as a result of safeguarding action being taken (but being safe on its own is not enough).

WE DID:

The Board has developed a set of **Safer Recruitment** principles for member agencies to adopt. This was prompted by the UK Border Agency identifying a significant number of people in a local care agency who did not have the correct documents to work in the UK. The Safer Recruitment principles are designed to help organisations to face the challenge of finding the right people to undertake care work in an increasingly difficult job market in central London.

In April, a review of the contributions made by Adult Social Care representatives to the work of the three **Multi-Agency Risk Assessment Conferences (MARACs)**[5] in the three boroughs was carried out. The largest proportion of adult cases at the MARAC involves people with mental health and substance use issues, and representation from the mental health trusts and substance-use providers at the MARACs is good. Adult Social Care teams work with older people and people with physical and learning disabilities. A very small percentage of MARAC cases involve adults from these groups, and of those referred to Adult Social Care, the majority do not meet the MARAC risk threshold, and any work is taken forward under Safeguarding procedures.

The actions prompted by the review findings included: ensuring Adult Social Care staff have the skills and knowledge to respond effectively to people who are experiencing domestic abuse, including working with controlling and coercive behaviour; clarifying local arrangements between safeguarding and the MARACs; providing evidence that the number of high risk safeguarding cases are being referred to the MARAC (nationally 10%).

Safeguarding in action

Ms. P is 37 years old, has physical disabilities and lives with her mother and brother. She was admitted to hospital where professionals were concerned about the care she received at home. She was underweight and dehydrated. It was alleged that one of her sisters may have physically harmed her. Her stay in hospital was authorised by a Deprivation of Liberty Safeguards (DoLS) standard authorisation.

As Ms. P recovered her health, it became clear that she wanted to return home to live with her family. She did not fully understand the circumstances that had led to her being in hospital, or why health and social care professionals were worried about her going home.

The DoLS Best Interests Assessor consulted Ms. P and her paid representative and decided it was not in Ms. P's best interest to remain in hospital as her treatment had ended and her health was restored. Some difficult conversations took place between Ms. P's mother, her social worker and health professionals.

An agreement was eventually reached about the care Ms. P would receive, which would keep her safe and well, living with her family and respects Ms. P's wishes as far as possible; Ms. P was discharged home..

[5] See Glossary.

OUTCOME 5

WE SAID:

We want the wider wellbeing of people to be maintained or enhanced as result of safeguarding activity.

WE DID:

We have developed a multi-agency **Safeguarding Information Panel**[6] which is a group of people with an interest in providing quality care in the three boroughs, who share information about where problems may be occurring, and plan with local providers how these can be addressed.

We have developed a way of **learning together from local and national case reviews**, including Winterbourne View; Gloria Foster; and Michael Gilbert, so that we begin to address some of issues that reviews repeatedly highlight, and work more effectively together and prevent further harm.

A **Pressure Ulcer Protocol** has been adopted across the three boroughs to help staff in all agencies identify where pressure ulcers may be a sign of neglect and indicate that a safeguarding enquiry may be needed.

In November 2014, agencies represented on the Board completed a **Self-assessment** of their organisation's safeguarding arrangements and developed action plans to address gaps.

This work has also informed the Board's strategic priorities for 2015/16.

Safeguarding in action

Mrs. J is a 63 year old woman who has a health condition that makes walking difficult. She disclosed to her occupational therapist that her daughter had stolen £15,000 from her bank account. The OT asked her what she would like to do about this. Mrs. J said she had already involved the bank and the police, which is why she knew it was her daughter who took the money.

Mrs. J didn't think she would get the money back but wanted some advice and information about how to find her daughter as she had left home. Mrs. J thought her daughter, who has learning difficulties, may have been put up to stealing the money by people who meant her harm, and Mrs. J was worried she may now be being exploited by the same people.

Mrs. J's OT supported her to contact the police, and to use web-based agencies who specialise in finding missing people.

"We have developed a way of learning together from local and national case reviews, to address issues they highlight"

[6] Members of the Safeguarding Information Panel include the Care Quality Commission; health and adult social care commissioners and safeguarding leads; placement monitoring and brokerage officers; and Healthwatch.

“We will survey people who have experienced a safeguarding enquiry during 2015/16 to see if Making Safeguarding Personal has made a difference”

“The Safeguarding Adults Case Review Group is adopting the ‘Learning Together’ model of reviewing actions taken in response to a concern”

“Agencies on the Board completed a self-assessment of their organisation’s safeguarding arrangements and developed action plans to address gaps”

“In next year’s annual report, having consulted more widely on the Board’s strategic priorities, we will be reporting what YOU SAID: and what WE DID”

PRIORITIES FOR 2015/16

What the Board learned in 2014/15

People who took part in the **Safeguarding Survey** (completed in July 2014) said that they want to be more in control of what happens to them when they have experienced abuse or neglect that has led to a safeguarding enquiry.

We learned together from national **Serious Case Reviews**, including Winterbourne View; Michael Gilbert; and Gloria Foster, that health and social care commissioners; contract and placement monitoring officers; safeguarding practitioners; the police; the ambulance service; the Care Quality Commission; general practitioners; and district nurses; each have a specific role to play in safeguarding people with care and support needs, and the importance of **good information-sharing** in preventing abuse and neglect, and in delivering safe and respectful care.

Local **Safeguarding Adults Reviews** are beginning to demonstrate that, although individual workers sometimes make flawed decisions, it is often the systems between organisations that let people down, and these need regular review and improvement in order to prevent deaths or serious harm.

Annual and peer audits of adult safeguarding case work show that practitioners in all organisations need to feel more confident in applying the Mental Capacity Act 2005 to decision-making, and in having difficult conversations with people about risk and safety.

The **Safeguarding Adult Risk Tool** (completed in November 2014) showed that PREVENT[7] training has placed a considerable burden on organisations, and a reduction of this burden is welcomed. Also, that engaging and retaining staff with suitable qualifications is becoming a challenge in health and social care in London.

Board members need to further develop their understanding of their new statutory responsibilities under the **Care Act 2014**, particularly with regard to:

- Safeguarding Enquiries (s42)
- Safeguarding Adults Reviews (s44)
- sharing information
- involving groups and communities that are not members of the Board, and people with care and support needs, and carers, in the work of the Board
- addressing the new categories of abuse, including domestic abuse, modern slavery, and self-neglect.

The **Making Safeguarding Personal**[8] pilot November 2014 to February 2015 showed us that practitioners and people who have experienced abuse or neglect welcome the approach, although it takes more time and some of the conversations can be difficult. Also that we need to develop practitioners' skills to work even more effectively with families, especially where the person causing harm is a family member, or where the person being harmed, is the carer of someone with care and support needs.

> **"The Safeguarding Adult Risk Tool showed that PREVENT training has placed a considerable burden on organisations, and a reduction of this burden is welcomed"**

[7] See Glossary.
[8] See Glossary.

What we will be working on in 2015/16

As a result of what we have learned in 2014/15, the Board has identified these priorities for 2015/16. These may change as a result of consultation:

There will be **more opportunities for people who have direct experiences of services, and their families and carers, to be involved in safeguarding adults work**, and the work of the Board. This will include:

- consulting on the Board's Strategy for 2016-19
- reviewing adult safeguarding information and advice that is available to the public
- being more involved in monitoring the quality of homecare provision in the three boroughs.

The **Making Safeguarding Personal**[9] approach will be adopted by all Adult Social Care and Mental Health teams when responding to disclosure of abuse or neglect, so that each person who has experienced abuse or neglect has as much control as possible in what happens next. This will include training staff to have difficult conversations; working with carer organisations to develop ways to support carers who may be experiencing abuse; increasing the use of advocacy in safeguarding; and developing Family Group Conferencing.

Agencies represented on the Board will continue to work together to ensure **local services are safe, respectful, and of a high standard**. This work will include:

- adopting Safer Recruitment practices
- using safeguarding data and learning from case review to inform health and adult social care commissioning, working with the Health and Wellbeing Boards
- building on the Compassionate Leadership programme
- sharing information about local provider performance, including the views of customers and their families, in order to support continuous improvement and prevent market failure
- continuing the work of aligning the work of the Board with the work of the Local Children's Safeguarding Board, and clarifying both Boards' relationship with the Violence Against Women and Children's Board, across the three boroughs. This is to make sure that agencies working with children and adults, who are experiencing different kinds of harm, are responsive, well-co-ordinated, and the best use is made of resources.

Board members are working with agencies to develop **better information-sharing**, possibly through an adult MASH arrangement, so that people with care and support needs who have experienced crime, have better access to the criminal justice system.

A response is being prepared to the findings of **the Law Commission Review of the Mental Capacity Act 2005** and the Board will implement any necessary changes to practice, and to the Deprivation of Liberty Safeguards service across the three local authorities and NHS.

The Board will complete the implementation of the **Care Act 2014** including clarifying the role of the **Designated Safeguarding Adults Manager** and improving **information-sharing** to assist the conduct of **Section 42 Enquiries and Section 44 Reviews**.

> **"Agencies will continue to work together to ensure services are safe, respectful, and of a high standard"**

[9] See Glossary.

MEASURING PROGRESS TOWARDS THE OUTCOMES

2014-15 was the first full year that all three local authorities collected information on safeguarding using the same forms and the same IT system. This section draws on this information to provide an indication of how well we are doing in achieving our strategic outcomes.

With the implementation of the Care Act in April 2015, some of the **terminology** surrounding safeguarding practice and procedures has changed. Previously, when someone reported a concern about an incident of potential abuse, the concern raised was known as a safeguarding alert. If the alert was assessed as requiring investigation under safeguarding procedures, it was then referred to as a safeguarding referral. Under the new terminology safeguarding alerts will be known as **safeguarding concerns** while investigations will be known as **safeguarding enquiries**.

Since the data presented in this section relates to the period prior to April 2015, we have retained the old terms here but in our day to day practice we are now using the new ones and will be using these when we report on our progress in future.

As part of the requirements of the Care Act, and also to make sure the person at risk is at the centre of the safeguarding process, we have amended and improved our documentation and forms for collecting information.

A key feature of this change has been the inclusion of sections which focus on the preferences and wishes of the person at risk and their family and friends. This means that in 2015-16 we will be in a much better position to say how well we are achieving what it is the person wants to happen, a goal which runs through all of our outcomes.

“In 2015/16 we will be in a much better position to say how well we are achieving what it is the person at risk wants to happen, a goal which runs through all of our outcomes”

OUTCOME 1

People are aware of safeguarding and know what to do if they have a concern or need for help

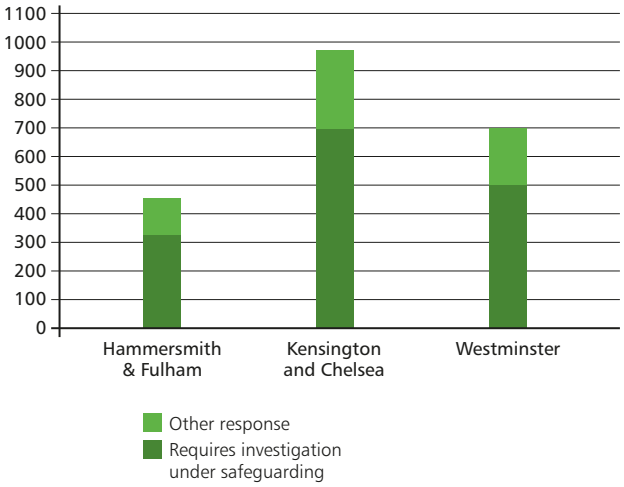
As people become more sensitive to potential safeguarding situations and how to respond to them, we would expect the number safeguarding alerts we receive to increase (assuming there is no change in the occurrence of abuse).

In 2014-15 we received, across the three boroughs, a total of 2,127 safeguarding alerts. The number received by each borough varied considerably: 972 by Kensington and Chelsea, 703 by Westminster, and 452 by Hammersmith & Fulham (Chart 1).

As each borough has had to change the way it records safeguarding information, in order to move to a common process and common IT system, it is difficult to draw comparisons with the number of alerts received in previous years but the number received by Kensington and Chelsea is a significant increase from the number received in 2013-14 (633), the number received by Westminster a slight increase (from 663), and the number received by Hammersmith & Fulham a notable fall (from 632). One of our priorities in 2015-16 is to determine how much of this difference is due to changes in systems and processes and how much is due to other factors such as the use of different safeguarding thresholds across the boroughs.

As people acquire a greater understanding of what constitutes a safeguarding incident, we would expect higher proportions of the alerts received to be assessed as requiring an investigation under safeguarding procedures. In 2014-15 in each borough about 70% of the alerts received were judged to require a safeguarding investigation. This is largely in line with the most recently reported average for London as a whole (68% in 2012-13).

Chart 1
Number of safeguarding alerts received in 2014-15 and whether or not they were assessed as requiring investigation under safeguarding procedures



OUTCOME 2

People are able to report abuse and are listened to

Although the number of alerts each borough received was very different, the number each received from different sources was, proportionately, very similar. Across the three boroughs as a whole about 70% of alerts were raised by staff working in social care or for the NHS. Just under 10% were raised by Housing and the Police and about 18% by a family member, friend or neighbour, or the person at risk themselves.

Chart 2 shows whereabouts the incidents occurred for all the investigations that were completed in 2014-15 (1,185 in total; 590 in Kensington and Chelsea, 350 in Westminster, and 245 in Hammersmith & Fulham).

Although safeguarding incidents are often associated in the media with care homes, this table shows that safeguarding incidents are much more likely to occur in people's own homes. In these situations, the person responsible for the abuse or harm is usually a home care worker or family member, though sometimes a stranger.

In about a third of the safeguarding investigations completed in 2014-15 the person alleged to have caused harm or abuse worked for an organisation providing social care, including home care agencies and residential care homes. Chart 3 shows that in these cases the type of abuse most frequently reported or alleged was neglect, or omitting to do something. In the other cases, where the person who caused harm did not work for an organisation providing social care, other types of abuse were reported more frequently.

Table 1
The sources of safeguarding alerts (2014-15)

	Hammersmith & Fulham %	Kensington and Chelsea %	Westminster %	Triborough area %
Social care	34.8	33.8	37.7	35.4
Health	38.1	33.6	33.2	34.6
Housing	4.1	3.5	5.3	4.3
Police	1.9	4.6	0.8	2.6
Education/Training/Workplace	0.0	0.7	0.8	0.5
Care Quality Commission	0.4	0.4	0.3	0.4
Self-referral	6.3	6.2	4.8	5.7
Family member	10.0	10.4	8.8	9.7
Friend/Neighbour	0.7	3.1	2.4	2.3
Other service user	0.7	0.7	0.8	0.7
Other	3.0	2.9	5.3	3.7
Total	100.0	100.0	100.0	100.0

Chart 2
Where incidents of alleged abuse occurred (based on investigations completed in 2014-15)

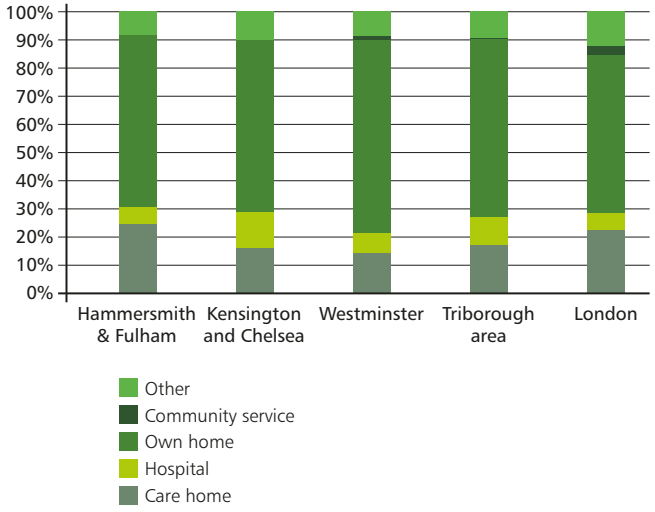
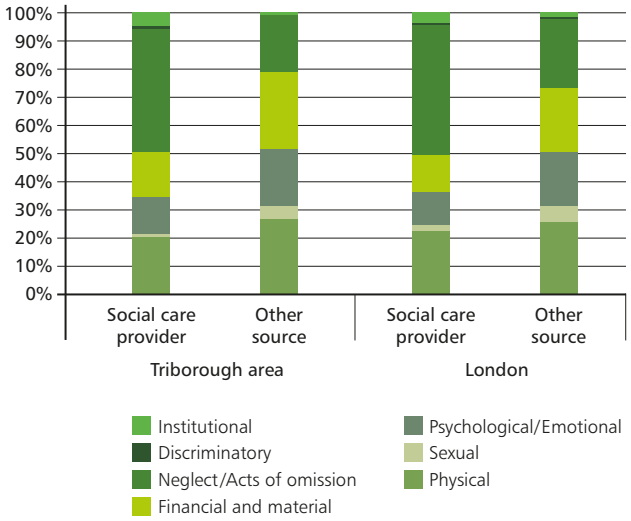


Chart 3
Types of alleged abuse according to whether the individual or organisation believed to be the source of risk was a provider of social care or support



“Across the three boroughs as a whole about 70% of alerts were raised by staff working in social care or for the NHS”

OUTCOME 3

Concerns about harm or abuse are properly investigated and people can say what they want to happen

One of the aims of any safeguarding investigation is to collect evidence about the allegation, evaluate it and come to a professional judgement about whether on the balance of probabilities it is believed to have happened.

Chart 4 shows that the outcomes of the investigations completed in 2014-15 were very similar across the three boroughs and consistent with the pattern for London as a whole. Across the three boroughs as a whole four out of ten completed investigations were substantiated or partially substantiated. Just over three out of ten were judged as not substantiated and just over two out of ten as inconclusive.

In Hammersmith & Fulham the proportion of completed investigations judged to be inconclusive has declined over the last three years to the extent that it is now similar to the proportions reported in the other two boroughs. This reflects a change of practice among professionals and an increased confidence among staff in making a professional judgement about the incident in the light of the available information.

When carrying out safeguarding investigations, the wishes of the person at risk should be paramount. Where someone lacks the capacity to make decisions about the safeguarding incident, we try to make sure that they have support from an independent person, who may be a family member, friend or formal advocate.

In 2014-15 the person at risk was assessed as lacking capacity to make decisions in relation to the safeguarding process in about 20% of completed investigations. In 69% of these cases the person was supported by a family member, friend or advocate. Although this is slightly higher than the London average (67%), it means that in three out of ten cases the person assessed as lacking capacity did not have independent support during the investigation.

Chart 4
Whether or not the allegations of abuse were upheld (based on investigations completed in 2014-15, excluding where investigation ceased)

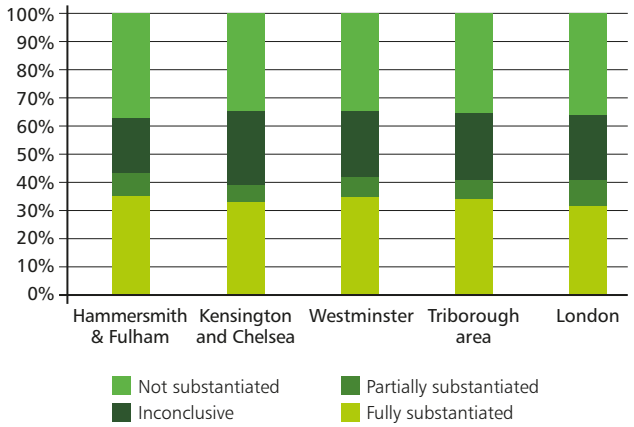
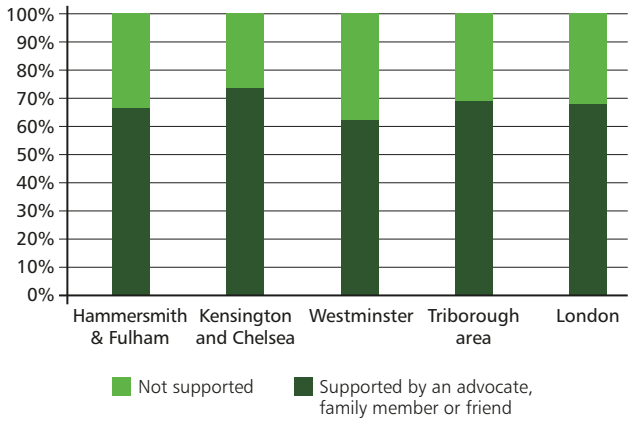


Chart 5
Whether those who were assessed as lacking capacity to make decisions in relation to the safeguarding process had support from an advocate, family member or friend



OUTCOME 4

People feel and are safer as a result of a safeguarding action being taken (but being safe on its own is not enough)

The overall goal of a safeguarding investigation is to achieve the outcomes the person at risk wants to achieve and improve their safety and quality of life and enhance their wellbeing. This may involve the removal of the source of risk, a reduction in the source of risk, or an acceptance of a given level of risk because of the particular circumstances, for example because the person wishes to stay in contact with a family member who was the source of risk.

Chart 6 shows that in 2014-15 action was taken to address the risk in 80% of completed investigations.
This was slightly above the London average (68%). Usually action is taken when the allegation is upheld. It can include a variety of things such as increased monitoring of the person at risk, referral for a social care assessment, disciplinary action for the alleged perpetrator, or action taken by another organisation such as a care home or the police.

The effect of this action in these investigations is shown in Chart 7. Although there was some variation across the three boroughs, the pattern was broadly similar. Across the three boroughs as a whole, the most frequently reported effect was a reduction in risk (54%). This was followed by a removal of risk (36%) and then no change in the risk (10%). This is largely consistent with the pattern for all London boroughs although across London slightly higher proportions of investigations resulted in the risk being removed and slightly lower proportions in the risk being reduced or unchanged.

In 2015-16, as part our drive to put the person at risk at the centre of the safeguarding process, we will be reporting on whether or not they felt that the process had resulted in their desired outcomes being achieved.

Chart 6
Whether investigations resulted in action under safeguarding

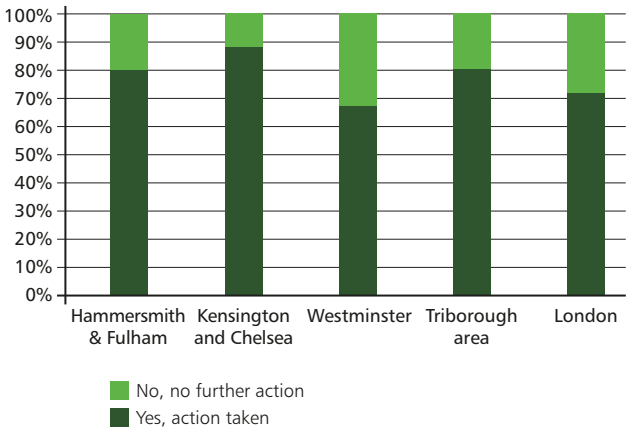
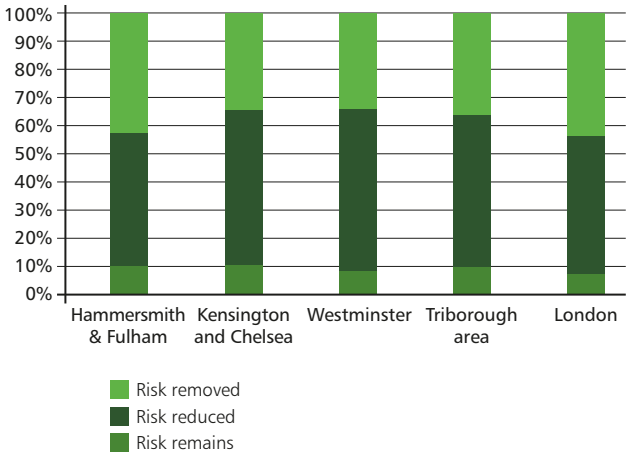


Chart 7
Whether as a result of the action the risk of abuse was judged to have been removed or reduced



Deprivation of Liberty Safeguards (DoLS)[10]

Local authorities assumed sole responsibility for authorising deprivations of liberty under the Mental Capacity Act 2005 in hospitals, and care and nursing homes from 1 April 2012.

On 19 March 2014 a Supreme Court judgement, known as Cheshire West, significantly lowered the threshold for what constitutes a deprivation of liberty.

As anticipated applications for DoLS authorisations increased ten-fold during 2014-15, as illustrated in Chart 8 (p.29).

Such a significant increase in activity placed considerable pressure on the resources of the DoLS service which covers the three boroughs. The service adopted a system which prioritised urgent authorisations, over standard authorisations, and took into consideration which people would benefit most from the safeguards being applied.

The lower priority applications are those that on the 31 March 2015 had not been completed, and are shown in dark green in Chart 9 (p.29).

Chart 10 (p.29) shows the proportion of cases that were not granted. This will be for a number of reasons, including that the person is ineligible for DoLS because they have capacity; or need to be treated under the Mental Health Act 1983; or it is not in their best interest to receive care and treatment in the hospital, care or nursing home who have applied for the authorisation to deprive them of their liberty.

“Applications for DoLS authorisations increased ten-fold during 2014/15. Such a significant increase in activity placed considerable pressure on the resources of the DoLS service”

[10] See Glossary.

Chart 8
Number of DoLS applications received in the reporting year

Chart 9
The outcomes of DoLS applications received in 2014-15, as of 31 March 2015

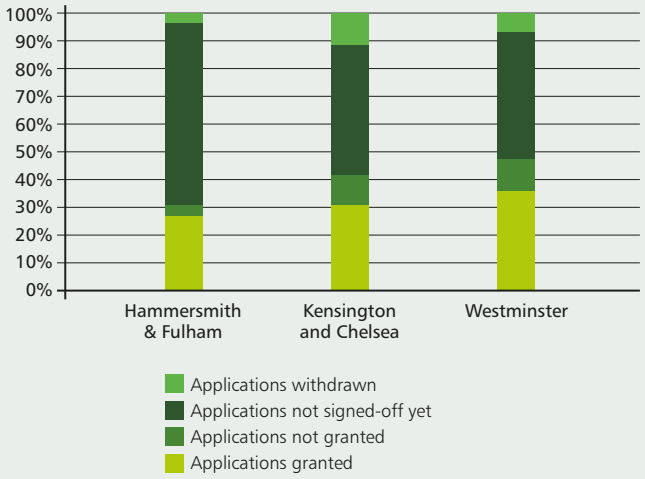
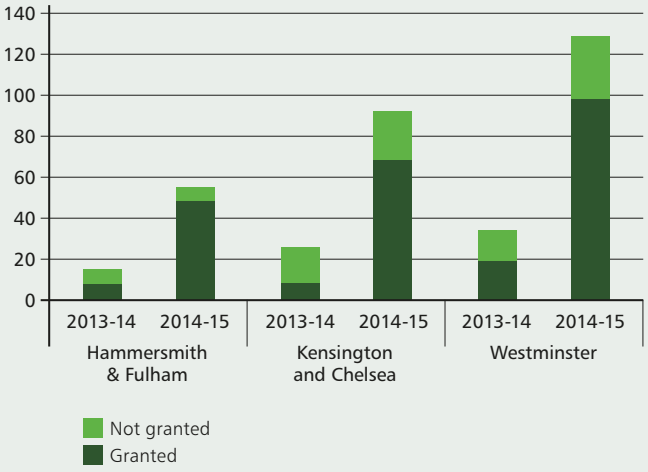


Chart 10
Number of DoLS applications completed in the reporting year which were granted/not granted



GLOSSARY OF TERMS

Deprivation of Liberty Safeguards (DoLS)

On 19 March 2014 a Supreme Court judgement, known as Cheshire West, significantly lowered the threshold for what constitutes a deprivation of liberty. The Court confirmed that to determine whether a person is objectively deprived of their liberty there are two key questions to ask, which they describe as the 'acid test':

1. Is the person subject to continuous supervision and control?; and
2. Is the person free to leave? (The person may not be saying this or acting on it but the issue is about how staff would react if the person did try to leave).

If a person is subject both to continuous supervision and control and not free to leave they are deprived of their liberty.

The judgement also said that a person could be deprived of their liberty in supported living and other domestic settings.

Once identified, a deprivation of liberty must be authorised in accordance with one of the following legal regimes:

- a deprivation of liberty authorisation, or Court of Protection order, under the Deprivation of Liberty Safeguards in the Mental Capacity Act 2005; or
- (if applicable) under the Mental Health Act 1983.

Making Safeguarding Personal

Making Safeguarding Personal starts with the principle that people are experts in their own lives. Whilst most people do want to be safer, other things may be as, or more, important to them; for example, maintaining relationships. So, staff are encouraged to ask people who have experienced abuse and neglect, 'What is important to you?' and 'What would you like to happen next?'.

MARAC (Multi-Agency-Risk-Assessment-Conference)

MARAC (Multi-Agency-Risk-Assessment-Conference) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. A survivor is referred to the relevant MARAC if they are an adult (16+) who resides in the borough and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

After sharing all relevant information they have about a survivor, the representatives discuss options for increasing the safety of the survivor and turn these into a co-ordinated action plan. The MARAC will also consider other family members including any children and managing the behaviour of the perpetrator. Information shared at the MARAC is confidential and is only used for the purpose of reducing the risk of harm to those at risk.

At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a survivor, but all may have insights that are crucial to their safety. The responsibility to take appropriate actions rests with individual agencies; it is not transferred to the MARAC.

Outcome

An Outcome is what the person who has experienced abuse or neglect wants from any work that is done with them. This may be that they feel safer but it also may mean that they feel that their choices and wishes have been respected. Measuring outcomes helps the Board to answer the question "What difference did we make?" rather than "What did we do?".

PREVENT

PREVENT is part of the government's counter-terrorism strategy. Its aim is to stop people becoming terrorists or supporting terrorism. Its relevance to the work of the Board is that safeguarding work can play a part is in protecting people at risk of harm from being drawn into terrorism-related activity against their will.

Safeguarding

Safeguarding means protecting a person's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and reduce the risk of abuse and neglect. When people have experienced abuse or neglect, safeguarding is about taking actions that are informed by the person's views, wishes, feelings and beliefs.

© By:design – October 2015 By:design 020 8753 3926 Ref: 172_7at Printed by Hammerprint 020 8753 2235 Printed on paper from sustainable sources

mistreated?
bullied?
hit?
neglected?
hurt?
exploited?
silenced?

Don't ignore it. Report it.

Hammersmith & Fulham
T 0845 313 3935
E h&fadvice.care@lbhf.gov.uk

Kensington and Chelsea
T 020 7361 3013
E socialservices@rbkc.gov.uk

Westminster
T 020 7641 2176
E adultsocialcare@westminster.gov.uk

h&f hammersmith & fulham

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

City of Westminster