Appendix 1

Safeguarding Adults Executive Board
Annual Report 2015-16

Courage, Compassion, and Accountability

Contents

Foreword

Mike Howard, Independent Chair of the Safeguarding Adults Executive Board

I am pleased to present the third annual report of the Safeguarding Adults Executive Board (SAEB) for Westminster, Kensington and Chelsea, and Hammersmith and Fulham. It is in a similar style and format to last year's report which was well-received. Much work goes into its compilation and it is gratifying to receive such positive comments.

The report describes how the Board's agencies, both jointly and independently, work to ensure the safety of those adults within the Boroughs who are deemed to be most at risk of harm through the actions of other people. In last year's report, I outlined the impact of the Care Act 2014 which gave a wider ranging definition of vulnerability. I also mentioned the establishment of a Safeguarding Adults Case Review Group. This group has developed over the past year and now has good representation from most Board agencies and is chaired by the Police Commander from Kensington and Chelsea.

The report focuses on the Group's work; they examine cases from a number of agencies working with local residents in the greatest need of protection but who, in some cases, have been let down by the 'system'. We do not seek to allocate blame, but rather look for opportunities for learning and to change practice. Some examples are summarised within the report.

The highest profile case involved a death in a care home, and led in September 2015 to the commissioning of a Safeguarding Adult Review from an independent reviewer from the Social Care Institute of Excellence. Mindful that such reviews can take many months, I set a deadline and the draft report was presented to the Board three months later. Work has taken place since January to act upon the findings of the Review. The report will be published in the autumn 2016 and a summary of strategic gains made will feature in next year's annual report.

After voicing criticism last year about the lack of funding, the Board now has received money from the Metropolitan Police; the London Fire Brigade; and the Clinical Commissioning Groups, with 'payment in kind' from the Central and North West London Mental Health Trust through use of meeting rooms.

The Board has done much over the past year to reach out to people living in the three boroughs. The Community Engagement work-stream is co-chaired by representatives from registered charities and they convened a consultation

workshop on 25th November 2015. The Care Act requires us to consult with the community and at the consultation event many of the eighty participants stressed the need for simple language. From this we developed the 'house' strategy which expresses in simple language what people said they wanted the Board to focus on for the next three years. We held a similar event this September to explain how we have acted upon the views expressed last year.

In the past, the Board has concentrated on the physical injury and neglect of local people. A major initiative for 2016 is to examine the mental and emotional harm caused by financial abuse or 'scams'. The Board now has a representative from Trading Standards, and examples of their work are mentioned in this report.

We also want to develop closer links with the network of Community Champions sponsored by Public Health. The Champions have an important role in creating local awareness about safeguarding matters, and we in turn can learn from them what really matters to people living in the three boroughs.

The case studies cite the difference that a safeguarding intervention makes to the life of an individual. Whilst the emphasis is rightly upon quality, there are some statistics about the safeguarding journey. The purpose is to show the number of concerns, and enquiries that result in some form of action and outcome for the person. It is important to show context so the data shows the size of the eligible adult population living in the three boroughs, together with those adults who have care and support needs.

Space precludes detailed mention of other projects championed by the Board in the past year; these include the production of a handbook to assist agencies to safely recruit staff for caring jobs; the on-going promotion of the principles and practice of Making Safeguarding Personal; and various training initiatives.

I am pleased that the Board continues to be well-supported and members have highlighted our work to other London Safeguarding Adults Boards as good practice.

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 the three boroughs who are in need of care and support.

Mike Howard, Independent Chair October 2016

What is the Safeguarding Adults Executive Board and is it doing what it is meant to do?

The Care Act 2014 says that the local authority must have a Safeguarding Adults Board from 1st April 2015.

The Safeguarding Adults Executive Board was set up in 2013 and provides leadership of adult safeguarding across the London Borough of Hammersmith & Fulham; the Royal Borough of Kensington and Chelsea; and the City of Westminster.

The Board is a partnership of organisations working together to promote people's right to live in safety, free from abuse or neglect. Its purpose is to both prevent abuse and neglect, and respond in a way that supports people's choices and promotes their well-being, when they have experienced abuse or neglect.

The Board believes that adult safeguarding takes **COURAGE** to acknowledge abuse or neglect is occurring, and to overcome our natural reluctance to face the consequences for all concerned of shining a light on it.

The Board promotes **COMPASSION** in our dealings with people who have experienced abuse and neglect, and in our dealings with one other, especially when we make mistakes. The Board promotes a culture of learning rather than blame.

At the same time, as members of the Board, we are clear that we are **ACCOUNTABLE** to each other, and to the people we serve in the three boroughs.

The Care Act says key members of the Board must be the local authority; the clinical commissioning groups; and the chief officer of police.

The Director of Integrated Care Adult Social Care and Health; the Deputy Director of Quality, Nursing and Safeguarding, Central Westminster Hammersmith Hillingdon and Ealing (CWHHE) Clinical Commissioning Groups Commissioning Collaborative; and the Borough Commander of the Metropolitan Police in the Royal Borough of Kensington and Chelsea; are the three statutory members of the Safeguarding Adults Executive Board.

The Care Act says these three must appoint a chair person who has the required skills and experience.

Mike Howard has been confirmed as the Independent Chair of the Safeguarding Adults Executive Board for a further two years.

The Care Act says the Board can appoint other members it considers appropriate with the right skills and experience.

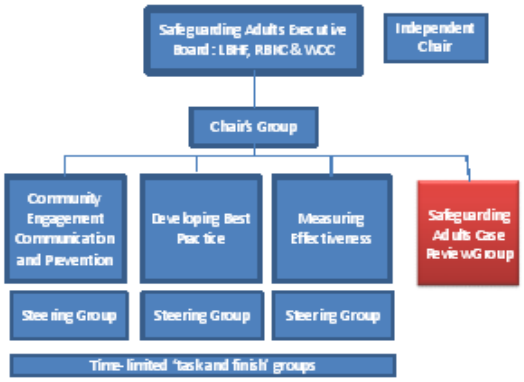
There are representatives on the Board, from the following organisations:

Imperial College Healthcare NHS Trust; Chelsea and Westminster Hospital foundation NHS Trust; The Royal Marsden NHS Foundation Trust; Central London Community Healthcare Trust; Central North West London NHS Foundation Trust; West London Mental Health Trust; London Ambulance Service; Healthwatch, Central West London; London Fire Brigade; London Probation Service; Children's Services; Elected members; Community Safety; Housing; Trading Standards; NHS England; HM Prison, Wormwood Scrubs; Public Health; Royal Brompton and Harefield NHS Foundation Trust.

There is now a senior 'go to' person in each of these organisations with responsibility for adult safeguarding. Their role as members of the Board is to bring their organsation's adult safeguarding issues to the attention of the Board, and to promote the Board's priorities, and disseminate lessons learned in their organisation.

An even wider group of people, including voluntary sector organisations; housing and homelessness agencies; advocacy and carers' groups ; and members of the public; all contribute to the four work-streams of the Board: Community Engagement; Developing Best Practice; Measuring Effectiveness; and Safeguarding Adults Case Review group.

The Safeguarding Adults Executive Board and work-streams



The Trust introduced a new operational model from September 2015 which has resulted in clear roles and responsibilities at a sector level, increasing representation at local authority Safeguarding Board meetings.
London Ambulance Service Safeguarding Annual Report 2015-16

The Board meets four times year and provides leadership and direction for adult safeguarding in the three boroughs. The work-streams meet more regularly. The Board is always mindful that the challenging work of preventing and responding to abuse and neglect is carried out by hard-working staff in all these organisations, every day of the year.

The Care Act says members may make payments for purposes connected with the Board.

The Local Authorities and the Clinical Commissioning Groups mostly fund the Board and its work-streams. This year, the Metropolitan Police Service contributed £5,000 per borough from the London Mayor's Fund; and the London Fire Brigade allocated £1,000 per borough to be shared between the Safeguarding Adults Board and the Local Safeguarding Children's Board. These contributions pay for the Board's administration costs; the independent chair; and externally commissioned Safeguarding Adults Reviews. The Board is planning to use these contributions to recruit a Board Business Manager to further improve its effectiveness and efficiency in 2016-17.

The Care Act says members may provide staff, goods, services, accommodation or other resources for purposes connected with the Board.

All the member organisations free up staff with the right skills and experience to contribute to meetings and to carry out the work of the four work-streams. Attendance is good and members are committed, and work hard to safeguard adults at risk of harm. Member organisations, in particular the Central North West London NHS Trust, have provided venues for Board meetings.

The Act says the Board must publish a report of what it has done during that year to achieve its objectives, including findings of the reviews arranged by it under Section 44 of the Act.

Despite the London Fire Brigade's non-statutory status on local safeguarding adult boards, to demonstrate its commitment to safeguarding the Brigade has made an offer of a £1,000 voluntary contribution to each of the 32 safeguarding adult boards (to be shared with children's safeguarding boards). In order to access this funding each borough is required to sign a Memorandum of Understanding agreeing to improve the lives of vulnerable persons within the borough by making appropriate safeguarding referrals when a concern is raised by the Brigade in carrying out its fire safety function; to agree to consider arranging and holding case conferences on particular cases when a Brigade representative requests following a fatal fire; and agreeing to make referrals of vulnerable persons to the Brigade to carry out Home Fire Safety Visits.
Extract from the London Fire Brigade Safeguarding Adults at Risk Audit Tool 2016-2017

This is the Annual Report of the Safeguarding Adults Executive Board. It is an account of what the Board set out to do in 2015-16 and what it has achieved.

This is the first full year that the Board has carried out its Section 44 duties to undertake Safeguarding Adults Reviews. These reviews are a legal requirement where a person with care and support needs has died, or suffered serious harm, as a result of neglect or abuse, and there is reasonable cause for concern about how agencies worked together to safeguard the person.

Cases that might meet the criteria for a review are considered by the Safeguarding Adults Care Review Group. This group is made up of representatives of organisations represented on the Board. The group recommends to the Chair of the Board the type of review that will provide a proportionate response to the concern, and the opportunity for most learning.

The report includes some of the learning from these Reviews and some of the changes that have been made to systems and practice as a result what has been learned.

In 2015-16 the first ever joint working protocols were agreed between the Violence Against Women and Girls Board; The Local Safeguarding Children's Board; and the Safeguarding Adults Executive Board.
The Violence Against Women and Girls Board has been working to strengthen relationships and improve referral pathways between specialist and statutory organisations.
The success of this is evident through the variety of sources of referral to the Angelou Partnership, and to the Multi-Agency- Risk Assessment Conferences, and joint working with the Metropolitan Central police to address trafficking for sexual exploitation and prostitution.

Extract from the Violence Against Women and Girls Strategic Partnership Annual Report 2015-16

Aspirations for 2015-16

In its 2014-15 Annual Report the Board made the following commitments for the year ahead:

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, including:

- consulting on the Board's strategic plan;
- reviewing adult safeguarding information and advice;
- involving families in monitoring the quality of provision in the three boroughs;
- Making Safeguarding Personal in response to all concerns raised about abuse and neglect.

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

- Adopting safer recruitment practices;
- Learning from case reviews to inform health and adult social care commissioning, working with the Health and Well-being 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 improvements and prevent market failure;
- Aligning the work of the Board to the Local Children's Safeguarding Board, and the Violence Against Women and Girls Board, to make sure 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 will continue to work together to develop better information-sharing, to assist with the requirements, from 1st April 2015, to conduct Safeguarding Enquiries conducted under Section 42 of the Care Act 2014, and Safeguarding Adults Reviews, under Section 44 of the Care Act 2014***,** including:

- Exploring the possibility of an adult Multi-Agency-Safeguarding-Hub (MASH).

We also said*:*

"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".

The things people told us are most important to them at the consultation event on 24th November 2015 that will shape the Board's priorities for the next three years

ADULT SAFEGUARDING STRATEGY 2016- 2019

Achievements in 2015-16

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

Consulting on the Board's strategic plan
On 25th November 2015, the Community Engagement Group held a very successful consultation event attended by eighty delegates, mostly members of housing, advocacy, and voluntary organisations, and local residents.

Delegates were asked what safeguarding meant to them, and what they wanted the Board to work on in the next three years. Everyone's ideas were captured on graffiti boards. From these ideas, we distilled the key themes which are in the **'house'**. These themes are deceptively simple, but challenging for organisations to consistently deliver. We are using these themes from the Consultation to guide the work of the Safeguarding Board and work-streams from now until 2018.

The **'house'** has two strands. The first is those things that people valued most in their dealings with statutory agencies, and which lead to **Creating a Healthy Community**. The second strand is what people said are the **Leadership Qualities** they expected from the Board and the organisations represented on it.

Leadership Qualities

You said: *I want to be listened to and for you to be willing to work with me.*
We said: *We are a partnership of listeners. We want to learn from you and we are open to new ideas.*

What WE DID
In addition to the consultation, we are involving more families and, where a person does not have friends or family, representatives, in monitoring people's experience of local provision in the three boroughs. This includes encouraging care and nursing homes to set up residents and relatives groups, which in some homes are called **'Quality Boards'**.

People are telling us that there is more to do to restore confidence in provision of care at home. A **Homecare Board** has been set up to oversee improvements in the delivery of care at home, and one of the measures of success will be **fewer safeguarding concerns being raised**.

The new **duty of candour** has seen an increase in patient involvement in enquiries into incidents in hospitals and community and mental health trusts that have led to significant harm. This 'duty of candour' has also been adopted in the Board's approach to Safeguarding Adults Reviews, as demonstrated in the 'Learning from Safeguarding Adults Reviews' section of this report.

The growing concerns reported in the media, and through local councillor surgeries, of 'scamming' and financial abuse of older people, has led the Board to put new emphasis on tackling **financial abuse** together. The Trading Standards team are making an invaluable contribution to the work of the Board. Below are two examples of how the Board has initiated joint work that is helping people escape the clutches of people who systematically aim to defraud them.

A Good Outcome

Adult Social Care asked advice from the Trading Standards team about a man of 75 years who had lost all his money (in excess of £200,000) on a fake lottery. He was facing eviction due to large rent arrears. Together, Adult Social Care and Trading Standards submitted a letter of support with his housing benefit application, and are pleased to report his arrears of £6000 have been paid off. They are working closely with his bank to ensure he is not loaned any more money and that his priority bills are paid. Of concern is that after six years of making payments to one lottery, and despite continued best advice, he remains convinced he has won the US lottery.

A Sad Outcome

A repeat victim on the priority referral list who a member of the Trading Standards had been working closely with, and had just signed up to the Mail Marshal scheme died at the end of August. He had been spending on average £50 per month over a five year period (£3000) and had only won £30. His sister said that he had lost far more than that but had not disclosed the real sum.

You said: *'We need to hold each other to account'*

What WE DID

As promised, we published the **Safer Recruitment Guide** which is available to organisations in printed and electronic copy, and to people who may be recruiting personal assistants to provide their care.

Safeguarding Adult Reviews have provided opportunities for change and improvement, and there is also a growing sense of trust and transparency between agencies; and hopefully families, with timely **information sharing** (subject to usual information governance arrangements); and a genuine desire to work together to improve people's experiences of safeguarding and prevent

further deaths and serious harm, caused by abuse or neglect.
To date, it has not been necessary to invoke Section 45 of the Care Act 2014 which gives the Board the authority to formally request information, if an organisation is unwilling to share information in the course of a safeguarding enquiry or review.

The Board continues to explore the value of creating an adult **Multi-Agency Safeguarding Hub** as part of the front door to adult services, including mental health services. A number of possible options are being considered, together with the resource implications of each. This year, the Board signed up to working protocols which have strengthened the working arrangements with the **Local Safeguarding Children's Board** and the **Violence Against Women and Girls Board,** and these boards' relationship with the Health and Well-being Boards.

The joint work with **Violence Against Women and Girls Board** has been particularly important in ensuring that if someone is experiencing domestic abuse, or modern day slavery, they are directed quickly and confidentially to the agency that can best assist them. The success of this joint work is evident through the variety of sources of referral to the commissioned providers specialising in Domestic Abuse; and to the Multi-Agency-Risk Assessment Conferences; and working with the Metropolitan Central police to address trafficking for sexual exploitation and prostitution.

Creating a Healthy Community

You said: *"I want to feel empowered to make choices about my own well-being. My choices are important."*

What We DID
Through staff training we are promoting the Care Act principle that each of us is the expert in our own life, and this applies equally when we are making choices about our health and well-being, and when we have experienced harm or abuse. Staff in our organisations are being trained to always ask people who have experienced abuse or neglect, or where appropriate their representative, *'What is important to you?'* and *'What would you like to happen next?'* This is what is meant by **Making Safeguarding Personal.** We are now recording whether or not each person has achieved what they hoped to achieve, as a result of safeguarding work.

We are developing a directory for use at service front doors that will make sure that people are directed to the most appropriate source of information and advice, to meet their needs.

You said: *"I want to be aware of what abuse looks like and feel listened to when it is reported."*

What WE DID

The safeguarding information leaflets **'Say NO to abuse'** have been up-dated and a new leaflet, '**Keeping safe from abuse and neglect: what happens after you report abuse'** has been published this year. Both of these and other information and advice about safeguarding adults are available on the **People First website**. Printed copies are also available on request.

The Safeguarding '**Train-the-trainers' programme** is being offered to the Community Champion leaders who will then offer the training to the **300 Community Champions** in 2016 -17. We are already learning from Community Champions how to work more effectively and sensitively with people who may be reluctant to disclose that they are being harmed, to statutory agencies.

You said: '*I want to be kept up-to-date and know what is happening after I have told you about abuse or neglect'.*

What WE DID

This has been a challenge for a number of years. Very often a lot of very good work is happening, but we do not routinely tell the person who has experienced, or reported harm, what we are doing. So we have **redesigned our safeguarding system**, and built in to it the requirement that our enquiry officers talk to the person or their representative about what has happened to you. They will ask you what you hope our enquiries will achieve for you. When we have finished our work, we will ask you if you have achieved what you wanted to achieve. We will be checking that this is happening through our **case audits**.

The **Measuring Effectiveness Group** is also running a **pilot** which will test what sort of responses people have had when they have raised a safeguarding concern. The findings from this pilot will be reported to the Board in the Autumn.

"There are clear safeguarding processes which are well understood and owned across operational teams".

"The three boroughs can seize upon the opportunity and willingness of users, carers, staff and stakeholders to create real involvement, building on the good practice that already exists."

Extract from the Peer Challenge for Adult Social Care Shared Services in London Borough of Hammersmith & Fulham; the Royal Borough of Kensington and Chelsea; and the City of Westminster 12th June 2015

Learning from Safeguarding Adults Reviews in 2015-16

The Safeguarding Adults Reviews that have been undertaken this year have provided insights into how effectively organisations are working together. A successful Review results in learning and improvements to systems and practice. A key lesson learned this year is that working with families, and using enquiries to answer their questions, gives everyone involved a better understanding of the circumstances that led to the serious harm, or death of their relative, and how to act to prevent future deaths or serious harm. It is hoped that this respectful way of working may help families towards recovering from their loss, which is very important to the Board.

In 2015-16 13 cases were accepted by the Safeguarding Adults Case Review Group as meeting the Section 44 Safeguarding Adults Review criteria. A list of the emerging themes from the Reviews is attached as APPENDIX 1.

These are some of the changes that have happened as a direct result of these Reviews:

- The security arrangements in the Accident and Emergency department in an acute Hospital have been tightened to make it more difficult for unaccompanied and vulnerable patients (for example, people with a learning disability, or dementia) to leave unnoticed.
- Delay in discovering the death of a man who had returned to a hostel on leave from hospital has led to a change to the welfare check procedures in the hostel to include daily checks of all unoccupied rooms. The hostel swipe-entry system is now disabled for people when they are admitted to hospital. This is so that when they return home from hospital, they have to check in with staff. Photos of residents are kept in the office to help new and temporary staff identify residents quickly.
- The leave and hospital discharge arrangements for people recovering from mental illness has been reviewed, and work is being done to improve communication and closer working between the Hospital and the hostel accommodation to which people are returning.
- The London Fire Brigade report all fatal fires to the Safeguarding Adults Case Review Group. As a result of a Review, the Brigade are currently working with the London Ambulance Service to pilot the provision of Home Fire Safety Visits to people who are at increased risk of fire from hoarding, as identified by the London Ambulance Service.

- A Homecare Board has been set up to address the local challenges of delivering safe and consistent care at home to residents of the three boroughs. The findings from three Reviews have confirmed that reducing risk and raising customer satisfaction with care at home is a priority area of work for agencies represented on the Board in 2016-17.

These are three examples of how the reviews have been conducted. They are used to illustrate the impact a death or serious incident have on agencies, and how they work together, and on families who have lost a loved one.

Ms. Adam's* was the first death reviewed by the Safeguarding Adults Case Review Group

*(*not her real name)*

Ms. Adam attempted to drown herself in the Thames, but was prevented from doing so by the police and detained in a local (mental health) Hospital. Within 24 hours, she absconded from the Hospital, and on her second attempt, did drown herself in the Thames.

As part of the Safeguarding Adults Review, the police and the Trust met to share what they had learned from this sad death, and agreed what each agency would do to prevent other, similar deaths occurring.

At the recent inquest into Ms. Adam's death, the jury found that Ms. Adam had been able to abscond due to inadequate security systems and processes at the Hospital, at the time.

However, the Coroner decided not to make a Prevention of Future Death report[1] because of the significant work that had been undertaken by the Trust to improve the security arrangements in the Hospital following Ms. Adam's death. The evidence provided by Trust's Chief Executive led the Coroner to reflect on how very difficult it is to get the balance right between creating the right environment (a hospital is not a prison) and the need for proper security.

The Coroner expressed praise for the joint work between the police and the Trust, which has led to the following measurable improvements:

In 2013 the police dealt with 104 mental health patients missing from the Hospital. When the joint work began, in 2014-15 this reduced to 62 missing persons, and by March 2016 was down to 40 patients. This reduction in demand has not only saved lives and made people safer, but has also saved an estimated £220,000 in police time, which can be spent on other aspects of policing.

Whilst escapes from the wards have effectively stopped, escapes during escorted leave have risen. The police, the Trust and hostels, are now working together to reduce the number of patients who put themselves at risk by

[1] Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths.

not returning to the Hospital when they should.
This case illustrates what can be achieved when agencies learn the lessons from a very sad and serious incident, and together use what they have learned to make changes to their systems and practices, to save both lives, and use scarce resources as effectively as possible.

The £220,000 has been calculated using the following assumptions:
If the police have a high risk missing person for 24 hours they deploy the following:

4 officers from the Missing Person's Unit (40 hours)
4 officers from Community Safety Unit (early / late and night duty) (120 hours)
1 Police Search Adviser team (12 officers x 6 hours) (72 hours)
4 officers from Emergency Response and Patrol Team (early / late and night duty) (120 hours)
1 officer from Casualty Information Unit (early / late and night duty) (24 hours)
1 member of Senior Leadership Team (2 hours per shift) (6 hours)
2 officers from Safer Neighbourhood Team (24 hours)

This equates to approximately £10,000 which is a conservative amount, and covers only the first 24 hours of officers' time.

Ms. Brewer's* was the first death to be reviewed by an external reviewer, using the Social Care Institute of Excellence (SCIE) Learning Together approach.
*(*not her real name)*
Ms. Brewer was living in residential care home, and was pushed over by a fellow resident. She was admitted into hospital with a broken hip. She also suffered a bleed on the brain as a result of her fall, and subsequently died in hospital.
Although the Review was prompted by the death of Ms. Brewer, the focus of the review was on how the man who caused her harm who, for the purposes of the review was called 'Andrew', came to be in a situation where he was able to inflict serious harm on a fellow resident.
Andrew's story is that the care he received from his partner made it possible for him to live at home, despite his severe dementia. After his partner died, Andrew spent some time in the acute mental health wards of two different hospitals, before being placed in a care home, registered to provide dementia care. Several professionals including social workers, nurses, and consultant psychiatrists, played a part in the decision-making about where Andrew's care and support needs would best be met.
Andrew stayed at the care home for two and a half months. He was removed after

the incident that resulted in Ms. Brewer's death.

The question the Review sought to answer was: *"What can we learn about how placements for people with dementia are commissioned, made and monitored across the three boroughs?"*

As a result of the Review, the recently constituted Joint Health and Social Care Dementia Programme Board is looking at the range and variety of provision for people with dementia, and how this might be commissioned and delivered in a more imaginative way. This includes looking at the experiences of other people with similar needs to 'Andrew' and seeing how well they are being served, and how they might be better served.
Work is being done to increase staff understanding of how placements are made and how in future, health and adult social care processes can become more seamless.
The Board is also exploring how information might be shared more effectively through single 'front doors' and arrangements such as a Multi-Agency-Safeguarding-Hub (MASH) for adults, such as the one that is in place for safeguarding children across the three boroughs.

The review of Ms. Connor's* death confirmed how important it is for communication between teams to be crystal clear, and that families need to have answers to their questions when they have lost a family member
*(*not her real name)*
Ms. Connor was discharged home from hospital and because of a mis-communication between two teams, the homecare package she had been assessed as needing was not put in place. When she died, Ms. Connor was not wearing the call alarm pendant with which she might have been able to summon help.
Although Ms. Connor's family were very much involved in her care, they were not informed of her discharge from hospital. Key learning for all staff involved in the Review is always 'think family'.

An extract from a letter to Ms. Connor's son and daughter.
Thank you for taking the time to meet with us to review the circumstances of your mother's death. Like you, we needed to understand what went wrong. We hope that our meetings have given you an explanation of what happened, and that you know how very sorry we are that we did not provide your mother with the care she needed, that may, or may not have extended her life.
For us, the meetings with you helped us to focus on what is important, and what we need to do to prevent something similar from happening to someone else's mother, father, or family member.
All the agencies involved with providing health and social care to your mother realised as soon as we learned of her death, that this was a serious matter that

needed to be fully investigated. I asked the Head of Service to meet you as soon as possible so that we could understand the questions you needed answering.
Each agency carried out their own internal enquiries, and we used this information to put together the timeline that we shared with you at our first meeting. I hope that sharing the timeline answered some of your questions, and that the second meeting you requested, provided you with a fuller account of what happened on the day your mother died, and the omissions which led to her not receiving the care she was assessed as needing.
In terms of actions, we are reminding all staff to ensure that pendent alarms are continually checked and placed around people necks.
A meeting with the hospital transport team has been called to ensure that all crews are aware of the importance of this and to ensure that when they take people home, the crews locate the pendent alarms and ensure they are within reach.
We are ensuring that all new referrals to the Service are accompanied by a letter confirming any conversations between the teams. This has been reinforced with all staff in the team, not just the person who omitted to confirm the bookings.
We have appreciated the way you have worked with us through this very difficult time for you and your family. We were especially touched by your generosity in the meeting when you said that whilst you felt that the staff involved had been negligent, you understood that they had not meant to harm your mother, and that you did not want them to be burdened by the guilt of what they neglected to do. We have passed your message to the staff involved.
Thank you for giving us permission to reflect with staff on the circumstances of your mother's death, so that we can all learn the lessons, and make changes to way we do things that will reduce the chances of something similar happening again.
Thank you also for giving us a copy of the lovely photo of your mother when she was younger. We will share this with staff in the 'learning together' session. It will remind us all that each person we work with has a story and, for those of us lucky enough to have family, how important our families are to us.
Please let me know if you have any questions that remain unanswered, or we have left anything out that is important to you.

In addition to the learning that Safeguarding Adult Reviews have provided this year, and opportunities for change and improvement, there is also a growing sense of trust and transparency between agencies; improved information sharing; and a genuine desire to work together to improve people's experiences of safeguarding and prevent deaths and serious harm, caused by abuse or neglect.

How we know we are making a difference?

Here are four examples of how the work of the Safeguarding Adults Executive Board is making a difference to people who are residents of the three boroughs.

How safeguarding has provided justice to a woman who had a crime committed against her, and is working to take unsuitable people out of the health and care work-force so that they can no longer take advantage of people for whom they are meant to be caring.

Mrs Smith* is a 93 year old woman who lives in a local care home, and funds her own care. A carer working in in the home stole £4,800 from Mrs. Smith 18 months ago. The carer was caught and was found guilty last week at the Crown Court. She is yet to be sentenced. The care home dismissed the carer under their disciplinary code and referred her to the Disclosure and Barring Service with the intention of preventing her from working in the health or care sector again.
*(*not her real name)*

How the Deprivation of Liberty Safeguards, which often get a negative press, is making a real difference to a person's well-being and quality of life.

Mr. Arnold* told the Best Interest Assessor who had come to assess him for a Deprivation of Liberty Safeguard (DoLS), that he did not mind living in his care home, but did not like sharing his room with strangers. On further enquiry, the Best Interest Assessor found out that the home had put up a curtain across Mr. Arnold's room and were using a second bed in his room for people needing respite care. The care home was told to put a stop to this immediately.
Mr. Arnold also told the assessor that he would like to live near the sea. The Best Interest Assessor made it a condition of the DoLS that Mr. Arnold's request to move to the seaside be explored. Mr Arnold was also given a paid representative to ensure that this happened, as he had no-one to represent him. In her most recent report, the paid representative wrote:
"When I asked Mr. Arnold how he felt about living in his new home, where he has now resided for about five weeks, he said 'I am happy here.' He then gestured

out of his bedroom window and said, 'I like the scenery and I go down the beach.' I said that staff had told me that he goes to the seafront twice a week, and I asked if he felt that twice was enough? Mr. Arnold and replied, 'That's enough for me.' Mr. Arnold is also planning to visit is brother along the coast in Devon where he lived as a child"
*(*not his real name)*

How agencies working together in the three boroughs are protecting people from scams, fraud and other forms of financial abuse that can cause emotional distress, increase social isolation, and can sometimes lead to illness and death.

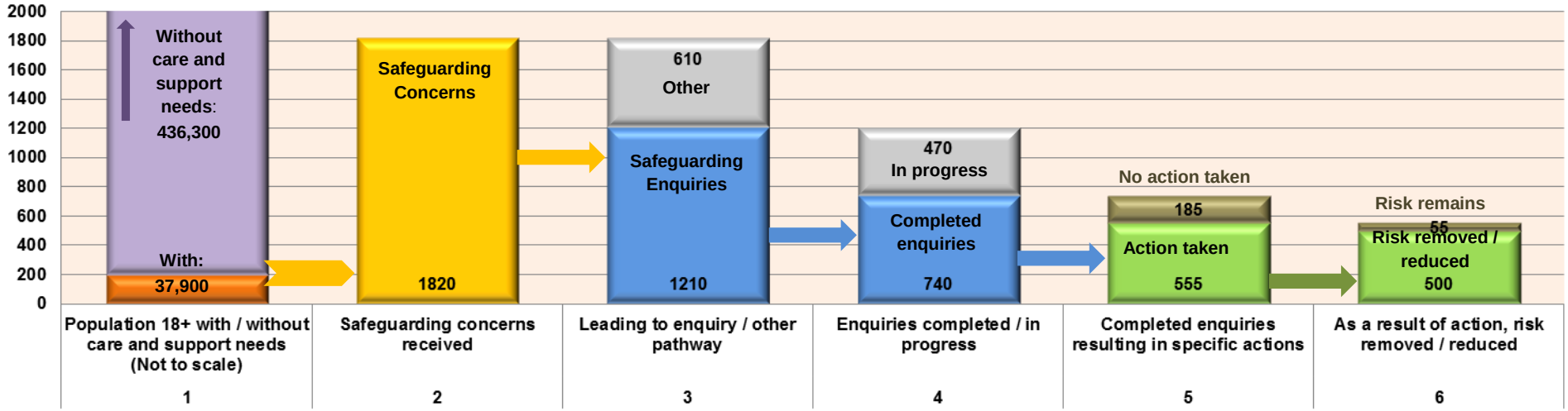
The social work team were worried about various financial transactions Mr. Price* was involved in, and had a conversation with colleagues in Trading Standards to see if there was any substance to their concerns. Mr. Price has been sending money to a woman living in a West African country, with whom he believes he has been having a relationship for the past 7 years. The amount of money he has sent is in the region of £15,000. Mr. Price manages his own finances, but is beginning to struggle to pay his bills. Trading Standards contacted the organisation through which the money was being transferred. Their enquiries uncovered that another 10 men were transferring money to the same woman, on the same basis as Mr. Price. These transfers have been intercepted, and the money transfer organisation is now investigating the potential fraud with the police. Mr. Price and other victims have not been informed as there are concerns that they might inadvertently tip off the recipient, which could seriously jeopardise any investigations. This decision has been made to protect public interest. The social work team are working with Mr. Price to link him in to some local organisations that will help to address his feelings of loneliness and social isolation, which scammers often exploit.
*(*not his real name)*

"A safeguarding meeting is a very stressful time for a family, and for a GP, however the meeting being so well chaired, so well informed, and so well prepared for, has, I believe, helped the carers and the family, and I, to improve the care we offer Mr. Jones, and made this event have a number of productive outcomes in terms of risk prevention."*
(*not his real name)

Extract from a letter from a local General Practitioner March 2016.

What are the numbers telling us?

Chart 1 The safeguarding journey, from raising of safeguarding concern to outcome of safeguarding enquiry, 2015-16



Raising of safeguarding concerns

- In mid-2015 the three boroughs (LBHF, RBKC and WCC) had a combined adult population of about 474,200.
- Using the percentage of adults aged 18+ who say in national surveys that they are unable to manage at least one self-care activity, such as washing or dressing, on their own (about 8%) as a proxy measure, we estimate that across the three boroughs about 38,000 adults have care and support needs. This is five times the number of adults who receive on-going support from social services
- In 2015-16 the three boroughs received a total of 1,820 concerns about cases of potential or actual harm or abuse. This is equivalent to about four concerns for every 1,000 adults in the general population, or 48 for every 1,000 adults with care and support needs, or 240 for every 1,000 adults receiving on-going social care (7,565)
- The majority of concerns were raised by health and care

Resulting safeguarding enquiry process

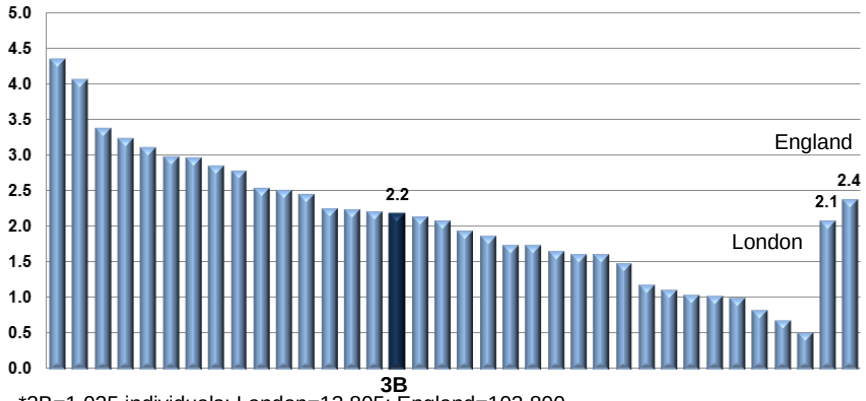
- About two-thirds (1,210) of the concerns received were assessed as requiring follow-up under safeguarding procedures.
- This is because the people involved were assessed as:
  (a) experiencing, or being at risk of, harm or abuse; and
  (b) having care and support needs which prevented them from protecting themselves.
- These concerns became the subject of a safeguarding enquiry to establish *what the person wanted to happen in relation to the risk* and what needed to be done to achieve this
- Those concerns (610) not followed up as safeguarding enquiries were followed up in other ways, for example by referral to trading standards offices, domestic abuse support agencies, the police or the customer services team.

Outcome of enquiry process

- Safeguarding enquiries can take varying lengths of time to complete, depending on the issues and organisations involved. At 31 March 2016 nearly two-thirds (740) of the enquiries that had been started since 1 April 2015 had been completed. The remainder were still in progress.
- Of the safeguarding enquiries which were completed in 2015-16, the majority (555, or about 70%) resulted in specific actions being taken in relation to the risk, such as disciplinary action or removing staff from the situation
- The remaining cases (185) had not resulted in specific actions for a number of reasons, for example because the inquiry had found the risk to be unfounded, or because the adult did not wish any action to be taken
- Where specific actions had been taken, in the great majority of cases (500, or 90%) the risk of harm or abuse was judged by the social worker to have been removed or reduced

A comparison with London and England 2015-16

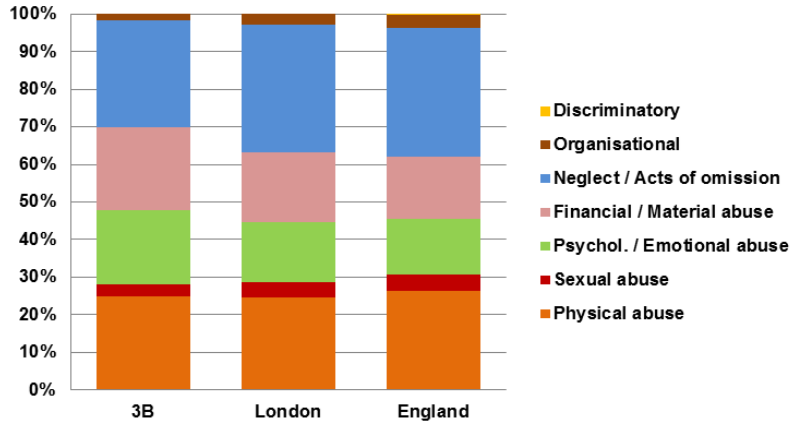
Chart 2 Number of individuals involved in safeguarding enquiries started in 2015-16, per 1,000 population aged 18+ - all London boroughs*



*3B=1,025 individuals; London=13,805; England=103,800.

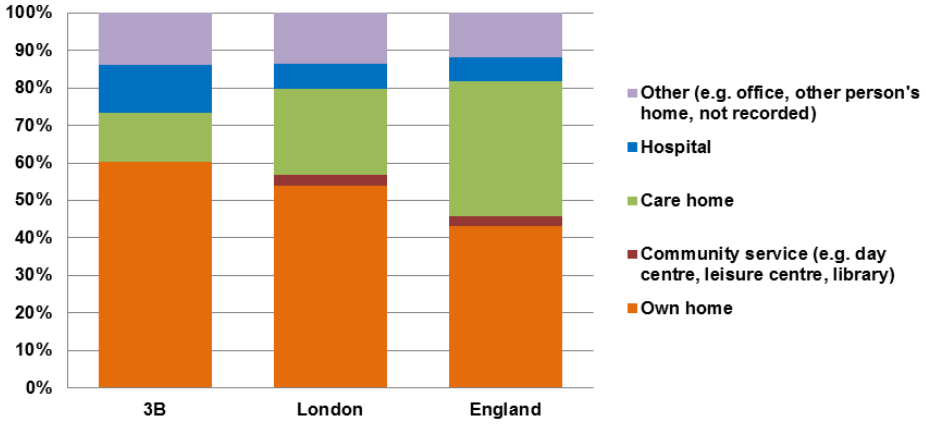
The number of safeguarding enquiries started per head of population varied considerably across London with 3B in the mid-range close to the London average.

Chart 4 Types of abuse alleged (enquiries completed in 2015-16)



The frequency with which different types of abuse were reported was similar across the country but in 3B proportionately fewer enquiries involved instances of neglect. These cases nearly always involved care providers.

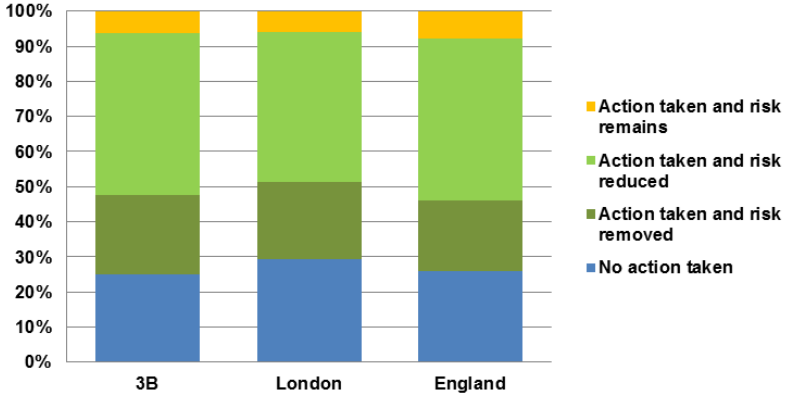
Chart 3 Where the alleged harm or abuse occurred*



*Based on the number of enquiries completed in 2015-16, regardless of when they started.
3B=935; London=13,045; England=108,910

Compared with London as a whole and especially England, a higher percentage of enquires in 3B related to abuse in people's own homes. About half of these involved care professionals and about half relatives, neighbours or strangers.

Chart 5 Whether, following action, the risk of abuse had been removed or reduced (inquiries completed in 2015-16)



In some cases safeguarding inquiries are unable to confirm the occurrence of abuse or identify a source of risk and do not require specific actions. But where they did do in nine out of ten cases the risk of abuse was reduced or removed. Where the risk remained this was with the agreement of the adult at risk.

What the Board will be working on in 2016-17?

The Board will continue to be guided by what people are telling us is important to them, as contained in the 'house'. We continue to work in the coming year on the three key areas of:

- Providing opportunities for people to be involved in safeguarding adults work, and the work of the Board;
- Working together to ensure local services are safe, respectful, and of a high standard;
- Developing better information-sharing.

To achieve these ambitions, the pieces of work we will be completing are:

- We will follow up on the consultation event and check with delegates and members of the public that the Board is doing what we said we would do.
- We will complete the review of our safeguarding systems and training to ensure that staff always ask *'What is important to you?' and 'What would you like to happen next?'* when you have reported a concern. We will also build the prompt to ensure you or the person who has reported the concern, is kept up to date with what is happening.
- We will be rolling out the Community Champions Training-the-training programme and evaluating how it is contributing to the health of the Community.
- We will continue to promote awareness of scams, fraud and financial abuse and tackle fraudsters by working together.

Learning from what the numbers are telling us we:

- We will be ensuring more timely ending of Safeguarding enquiries;
- We will be exploring in more detail what is happening in people's homes where the person causing harm is a relative, neighbour or stranger, and thinking about new ways of working that can help.

Learning from Safeguarding Adults Reviews:

- We will be publishing the Reviews and tracking progress on the changes made as a result of the findings and disseminating the learning;
- We will be tracking the progress made by Joint Health and Social Care Dementia Programme Board in developing the range and variety of provision for people with dementia;
- We will be working together to improve the life chances of people living in hostels, with mental health problems, and those who use substances;
- We will be raising awareness of fire risks, and working together to reduce the incidence of fatal fires;
- We will be working on increasing people's confidence in the provision of care at in their own home.

We will continue to involve people and their families in planning safeguarding enquiries and reviews, to better understand what has happened and learn what might prevent something happening again.

Glossary of terms

Safeguarding means protecting and adult'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.

Making Safeguarding Personal starts with the principle that you are expert in your own life. Whilst many people do want to be safer, other things may be as, or more, important to you; for example, your relationship with your family, or your decisions about how you manage your money. So, our staff are being encouraged to always ask you *'What is important to you?'* and *'What would you like to happen next?'*

An Outcome is what you hope to get out of the conversations we have, and the work we do with you. Measuring outcomes helps the Board to answer the question "*what difference did we make?"* rather than *"what did we do?"*

Deprivation of Liberty Safeguards (DOLS) When a person in a care, or nursing home, or hospital, is subject to continuous supervision and control from staff, and is not free to leave, under the Supreme Court judgement known as 'Cheshire West', they are deprived of their liberty. Once identified, a deprivation of liberty must be authorised either by the Court of Protection order; or under the Deprivation of Liberty Safeguards in the Mental Capacity Act 2005; or under the Mental Health Act 1983. If it is not authorised, under the law, it is an illegal detention.

Multi-Agency-Safeguarding-Hub (MASH) The purpose of a Multi-Agency Safeguarding Hub (MASH) is to gather information from various professionals in order to make a brief assessment of a child and/or a family, or an adult, who is at risk of harm, to ensure their immediate safety and meet their welfare, or care and support needs. The MASH aims to improve the quality of information sharing between professionals in order to make timely and informed decisions based on accurate and up-to-date information. This assists to ensure that the child, their family or the adult at risk of harm, is provided with the most appropriate offer of supports and services, as soon as possible.

Duty of Candour is a legal duty on hospitals and community and mental health trusts, to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate, truthful information from health providers.

APPENDIX 1 Cases Accepted for Safeguarding Adults Review in 2015-16 and emerging themes

	Date case to SACRG	Emerging themes from Safeguarding Adults Reviews
1.	06/03/2015	The mismatch between the needs of older people with dementia and the range of appropriate provision to meet those needs ('requisite variety'); information-sharing between agencies. **(Case included because subject to a Review using Social Care Institute for Excellence Learning Together, September to December 2015 and shortly to be published)**
2.	29/05/2015	The challenges of providing suitable housing for a mix of adults with a range of needs, including drugs and alcohol use; mental health problems; physical frailty; age related conditions; and of keeping this mix of people as safe and secure as possible, particularly in hostel accommodation.
3.	10/07/2015	Staff confidence with application of the Mental Capacity Act in complex and life-threatening decision-making and support for staff when a capacitated decision is unwise, and as a result a person dies or suffers serious harm.
4.	10/07/2015	The challenge of how to effectively hold a private General Practitioner to account with regards to their clinical decision-making; and their application of the Mental Capacity Act; and end of life care.
5.	01/10/2015	The challenges of good information sharing, when electronic systems do not talk to each other; the need for secure handover of cases between agencies and teams within agencies; and to prevent the serious consequences of 'dropping the baton'.
6.	02/10/2015	The challenge of working with people with capacity who are reluctant to accept care from statutory services which results in their physical health care needs not being met.
7.	13/11/2015	The review of leave and hospital discharge arrangements for people recovering from mental illness, and the need for improved communication and closer working between hospital and the hostel accommodation people are discharged home to.
8.	13/11/2015	The value of working with relatives and families to prevent harm, and involving them as soon as possible when harm or death has occurred so their questions can help to inform the enquiries and reviews, and provide them with some answers.
9.	05/02/2016	The review of leave and hospital discharge arrangements for people recovering from mental illness, and the need for better communication and closer working between hospital and the hostel accommodation people are discharged home to.
10.	05/02/2016	The challenges of good information sharing, when electronic systems do not talk to each other; the need for secure handover of cases between agencies, and teams within agencies; and the serious consequences of 'dropping the baton'.
11.	05/02/2016	Quality of home care provision and risks associated with transfer of contracts to new providers
12.	18/03/2016	Quality of home care provision and risks associated with transfer of contracts to new providers
13.	18/03/2016	Adequacy of transport arrangements for an older patient between a mental health facility and an acute hospital