Havering Safeguarding Adults Board

Annual Report 2016-2017

Havering Safeguarding Adult Board Chair Forward

Welcome to the Havering Safeguarding Adult Board (HSAB) Annual Report 2016-17.

The past year has seen second year of the Care Act 2014. This has seen increased understanding and application of 'Make Safeguarding Personal'. It is still in its infancy and the board over the coming year will continue to support improved awareness across all agencies and monitor its application.

For safeguarding to be effective it has to be everyone's business. One of the major challenges for the board has been and will continue to be the raising of awareness, not only of agency staff but with the public. To this end this year has seen the introduction of the Community Engagement sub group made up of 12 voluntary organisations. Their involvement with the board is invaluable when it comes to increasing awareness.

The introduction in 2016 of the first Safeguarding Week combining not only Adult Safeguarding but Children Safeguarding was very successful with not only the HSAB conference but many short seminars across many areas impact on safeguarding being very well attended. This week demonstrated the commitment of safeguarding and raised awareness with the involvement of the local media.

This year has also seen the completion of a Safeguarding Adult Review which focused on the death of a young lady who had been involved with children services as a young person but when she turned 18 years of age faced the difficulties of transitioning into adulthood and the adult services. This case has led to fundamental changes in the way transitioning of young people into young adults will be supported in the future. This work and positive response to the case has only been possible due to the openness and honesty of individuals involved with the young lady and then the complete involvement of the Directors Adult and Children Services.

As the Chair of the HSAB, I would like to thank everyone who has shown such commitment to all this work and have thereby shown commitment to safeguarding and the desire to improve the outcomes of vulnerable adults.

The Board is very interested in your views about this report – please do let me have feedback at brian.boxall@havering.gov.uk

Brian Boxall
Havering Safeguarding Adult Board Independent Chair

Introduction

The purpose of this report is to fulfil the statutory requirement set out in Care Act 2014, which states that all Safeguarding Adults Boards (SAB) must publish an annual report on the effectiveness of safeguarding in their local area.

The Care Act 2014 came into force in April 2015 and the Havering SAB became statutory. The purpose of the SAB is to help and safeguard adults with care and support needs. It does this by:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance;
- assuring itself that safeguarding practice is person-centred and outcome-focused;
- working collaboratively to prevent abuse and neglect where possible;
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred; and
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

This report will provide an overview of the following:

1. HSAB activity 2016-17.
2. Adult Safeguarding Activity 2016-17.
3. HSAB Governance 2016-17.

Appendix: Each agency was asked to supply a summary of their strengths and areas for development in respect of safeguarding in 2016-17. These reports are attached to the annual report in the appendix.

Our Vision

'To make sure that Adults at risk from harm in Havering are safe and able to live free from neglect and abuse'.

At the centre of all we do are the **Six Adult Safeguarding Principles**, and our business plans and performance monitoring reflect these:-

EMPOWERMENT – people feeling safe and in control, encouraged to make their own decisions and giving informed consent. People feeling able to share concerns and manage risk of harm either to themselves or others

PREVENTION – it is better to take action before harm happens, so good information and advice are really important

PROPORTIONALITY – not intruding into peoples' lives more than is needed by responding in line with the level of risk that is present

PROTECTION – support and representation for those adults who are in greatest need because they are most at risk of harm

PARTNERSHIP – working together with the community to find local solutions in response to local needs and issues

ACCOUNTABILITY – being open about what we are doing and responsible for our actions - focusing on outcomes for people and communities.

Adult Safeguarding Concerns and Enquiries

The below chart sets out the separation between adult safeguarding concerns and welfare concerns.

Concerns and Enquiries		
	2015-16	2016-17
Adult Safeguarding Enquiries		
Number of Enquiries	668	818
Social Care Staff	279 (42%)	333 (41%)
Health Staff	186 (28%)	257 (31%)
Police	31 (5%)	73 (9%)
Adult Welfare Concerns		
Number Welfare Concerns	3011	2649
Social Care Staff	699 (23%)	342 (13%)
Health Staff	481 (16%)	442 (17%)
Police Merlin	1564 (52%)	1632 (62%)
Total Number of Enquiries and Concerns	3679	3468

Safeguarding Enquiries
The source majority of safeguarding enquiries was social care (CASSA and Independent). A significant percentage of those came from residential care staff.

Health staff continued to raise a significant % of safeguarding concerns whilst those raised by police are minimal. The number of repeat enquiries remains steady at 13.9% slightly down from 15% in 2015-16.

Welfare Concerns
The number of welfare concerns has slightly reduced. The source of the majority of the welfare concerns still remains police merlins.at 61%. This is a significant percentage rise from the previous

year. There has been a significant reduction in welfare concerns raised by social care staff.

Abuse Types

The Care Act 2014 added four new categories of abuse, Domestic Abuse, Sexual Exploitation, Modern Slavery and Self Neglect.

Abuse Type		
TYPE	2015-16	2016-17
Physical	258 (37%)	136 (16%)
Sexual	18 (3%)	27 (3%)
Emotional	57 (8%)	51 (6%)
Financial	125 (18%)	69 (8%)
Neglect	224 (32%)	500 (60%)
Discriminatory	1	1
Institutional	6	1
Domestic Abuse	1	5 (1%)
Sexual Exploitation	0	1
Modern Slavery	0	0
Self Neglect	16 (2%)	39 (5%)
TOTAL	706	830

This year has seen a significant change in two of the categories. As a percentage of the total, recorded physical abuse is down from 38.6% to 16.6% and neglect is up from 33.5% to 61.1%. It is not clear why this has taken place and will be an area for the board to monitor. There has been a slight increase across the new four categories but the board need to increase knowledge and activity to detect sexual exploitation and modern slavery.

The majority of referrals are related to incidences of neglect and omission especially within Care Home settings. Referrals relating to financial and physical abuse were more prevalent within own home settings.

Board Challenge

For board to increase awareness of the four new categories.

Abuse location and relationships

The home remains the biggest location for abuse to take place followed by residential care homes.

Abuse Locations		
Location	2015-16	2016-17
Own Home	284 (42.6%)	404 (49.3%)
Care Home –Residential	174 (26%)	214 (26%)
Care Home- Nursing	105 (15.8%)	129 (15.8%)
Hospital	29 (4.3%)	12 (1.5%)
Service within the community	3 (0.4%)	4 (0.4%)
Supported Living	43 (6.5%)	26 (3.2%)

This position is reflected in the data in respect of the relationship between the abused and the abuser. 56% related to relatives and family carer and care supporter in the private sector. However there has been a significant decrease in the relative/family carer category.

Relationships		
Relationship	2015-16	2016-17
Social Care Support- Public Sector	2.2%	0.7%
Social Care Support -Private Sector	48.7%	44.4%
Relatives/Family carer	20.9%	12.2%
Health	4.5%	5.7%

With the emphasis on finding ways of supporting vulnerable adults in their own environment and the use of direct payments, the board will need to continue to work to monitor the quality of the services being provided to support this approach.

Safeguarding Referrals Outcomes

An enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.

The Care Act requires local authorities to make proportionate enquiries (or to make sure that, as the lead agency, enquiries are carried out by the relevant organisation) where there is a concern about the possible abuse or neglect of an adult at risk.

This may or may not be preceded by an informal information-gathering process, if that is necessary to find out whether abuse has occurred or is occurring and therefore whether the Section 42 duty applies.

There has been a significant increase in the number of enquiries but the number completed within 25 days has also increased to 80%.

Strategy Activity	15/16	16/17
Enquiries Completed	603	738
Completed within Timescale (25 working Days)	437 (72.5%)	595 (80.6%)
Enquiries open for 2 months	112 (18.6%)	80 (10.8%)

Board Challenge:

- *With the emphasis on providing support to vulnerable adults in order to enable them to remain within their own home environment, the HSAB need to continually ensure that this environment remains safe. This will be undertaken through audits and increased information available to the public.*

Making Safeguarding Personal

Making Safeguarding Personal (MSP)[1] is a sector led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances.

MSP seeks to achieve:

- A personalised approach that enables safeguarding to be done with, not to, people
- Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion'

[1] www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal

- An approach that utilises social work skills rather than just 'putting people through a process'
- An approach that enables practitioners, families, teams and SABs to know what difference has been made

Making Safeguarding Personal is at the centre of safeguarding and for the first time this Annual Report is able to start to gauge the impact of Making Safeguarding Personal.

Making Safeguarding Personal		
	2015-16	2016-17
Completed Safeguarding Enquires	603 (91.5%)	738 (94.6%)
Case note recording		
Number where a MPS case note has been recorded	552	698
Individual or representatives asked about desired outcome	293	402
Asked but outcome not expressed	104	186
Were not asked	84	69
% of achievement when outcomes expressed		
Fully achieved	68%	65%
Partially achieved	26%	28%
Not achieved	4.8%	6%

There is evidence that MSP is starting to be considered and applied but there is a need to improve knowledge and awareness across all agencies not just social care. The achievement of outcomes expressed is only at 65%. There is still improvement to be made in understanding how to ask about desired outcomes and recording.

Board Challenge

To continue to monitor the application of MPS principles

To support awareness raising and improved application across all agencies.

Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS)

Article 5 of the Human Rights Act[2] states: "everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty (unless) in accordance with a procedure prescribed in law."

The Mental Capacity Act outlines how an individual can be deprived of their liberty in order to care for them safely, and Deprivation of Liberty Safeguards (or DoLS) is one such procedure prescribed in law that is invoked to protect the peoples and ensure their loss of liberty is lawful. Care should always be provided in the least restrictive way possible, and those responsible for providing care should explore all options.[2]

DoLS are an amendment to the Mental Capacity Act 2005 that applies in England and Wales and can only be applied in a care home or hospital setting.

An individual is deprived of their liberty for the purposes of Article 5 of the European Convention on Human Rights if they:

- lack the capacity to consent to their care/treatment arrangements
- are under continuous supervision and control
- are not free to leave.

The application of MCA and DOLS has remained a major focus of the board. Highlighted in last year's Annual Report was the Supreme Court Judgment 'Cheshire West' which has continued to significantly impact on the number of applications during 2016/17. It changed the definition of who was considered to be deprived of their liberty to include anyone living in a hospital, care home or private settings who is under constant supervision and is not free to leave.

The increase is reflected in the below chart.

DOLs		
	2015-16	2016-17
Applications received	552	1083
Granted and signed off	135	360
Applications not appropriate or withdrawn	75	227

[2] www.mentalhealth.org.uk/a-to-z/d/deprivation-liberty-safeguards-dols

Care establishments

There are currently 39 Residential and Nursing Homes; 11 Domiciliary Care Agencies and 5 Day Opportunities, 27 Learning Disability (LD) Homes, 11 LD Day Opportunities, 3 Extra Care provisions and 14 LD Supported Living establishments, which are monitored by the Quality Team.

During 2016-17 the Local Authority Quality Team suspended the local use of six establishments for various periods of time whilst the initial identified concerns were remedied.

This monitoring process provides assurance that complaints against establishments are being dealt with appropriately.

HSAB Governance and structure

Governance

The HSAB is chaired by an Independent Chair; the appointment was made by a panel which was chaired by the Chief Executive. The Independent Chair holds meetings with the Lead Member for Adult Safeguarding, the Chief Executive and the Director of Adults. The purpose of each meeting is to hold the Independent Chair to account for the effectiveness of the HSAB and to provide space to ensure open and honest discourse between the Director of Adult Services and the Independent Chair regarding the service activity as it relates to adult's safeguarding within Havering.

The three statutory partners are represented at the HSAB at an appropriate level and actively participate within the business of the Board. The SAB also consists of members of non-statutory agencies.

There has been difficulty in securing/maintaining regular attendance from NHS England. The impact of this has meant strategic insight into NHS England priorities and direction of travel from Board discussion. The structure of Havering's SAB was reviewed during 2015 in order to strengthen governance processes to support the Board to manage business priorities more effectively as the Board's responsibilities increased.

Structure

Executive Board

The Executive Board is chaired by the Independent chair; it has a small membership consisting of the strategic leads from all statutory partners and holds ultimate responsibility for the effectiveness of the multi-agency safeguarding offer to adults in Havering.

The Executive Board formally agrees:

- Business priorities of the board and the business plan
- The Annual Report
- Final overview reports and recommendations from Safeguarding Adults Reviews (SARs)
- Action plans to respond to SAR/Learning Review recommendations

- Actions to respond to Board risks and the responsible working group/partner organisation to progress the actions.

Operational Board

The Operational Board is chaired by the Independent Chair and has senior staff with links to practice within the membership. All members actively participate within the discussions and this is evidenced within minutes of meetings. The Operational Board's agenda includes both children and adult priorities to ensure that cross cutting priorities are considered by both strategic boards.

The Operational Board is in place to provide overview and scrutiny of the progress of HSCB/HSAB Business plan priorities and to provide assurance to the SA/SC Executive Boards in relation to the progress of business plan objectives. Concerns that are identified by the Operational Board and HSAB/HSCB working groups in relation to the effectiveness of the safeguarding offer are added to the HSCB/SAB risk register, monitored by the Operational Board and reported to the Executive Boards.

Progress of the HSAB action plan is monitored by the Operational Board. The Operational Board drafts the Executive Board agenda to ensure that it is appropriately focused on relevant areas of business.

Operational Board minutes are circulated to Executive Board to allow for scrutiny and challenge of business activities.

HSAB Sub Groups

The HSAB is supported by five sub-groups:

(1) Quality, Effectiveness and Audit Sub Group

The Quality, Effectiveness and Audit Sub Group is a multi-agency group chaired by a member of NELFT's SMT and includes members from London Borough of Havering, NELFT, BHRUT, CCG and Metropolitan Police.

During 2016-17, the group met on 5 occasions. Keys areas that were progressed by the group were:

Performance measures and monitoring

The group is responsible for developing and monitoring performance against relevant measures and indicators and for reporting this performance to the HSAB. During the year, the group reviewed and revised the safeguarding measures so that they more fully reflect multi-agency performance and align more closely with the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability. This proposal was accepted by the HSAB and this will be used as a basis to measure the effectiveness of the HSAB's organisations in 2017-18.

Self-assessment and Association of Directors of Adult Social Services (ADASS) audit tool

The group discussed and considered the issues raised by a self-assessment tool recommended by London Chairs of Safeguarding Adults Boards (SABs) network and NHS England (London) through

ADASS for use by safeguarding partners. On the group's recommendation, the HSAB requested that all agencies and partners in Havering complete a self-assessment based on the ADASS audit tool in early April 2017. The group will perform a peer challenge exercise on the returns during 2017-18. The results will be reported back to HSAB and it is intended that this will identify strengths in safeguarding arrangements, common areas for improvement, single agency issues that need to be addressed and partnership issues that may need to be addressed by HSAB.

The audit tool incorporates a section on Making Safeguarding Personal (MSP). In addition to completion of the tool, the group considered that, in order to validate further the findings on MSP, members should contact a small number of service users involved in a recent safeguarding enquiry in order to check directly with them about whether their consent had been obtained to the enquiry. The group discussed and planned how these exercises could be carried out and the results will be reported back to HSAB during 2017-18.

Multi-agency audit tracker

The group has developed a multi-agency audit tracker that it updates on a six monthly basis. This provides an overview of the audits with a safeguarding element that have been undertaken by different members of the group and summarises the key findings, the actions resulting from the audit and the individuals involved.

Other safeguarding issues

In addition to the above, the group reconsidered and updated its terms of reference, discussed a multi-agency project to examine the processes and practices used to discharge patients with support needs and discussed a three agency review (BHRUT, NELFT and CCG) of pressure ulcers aimed at considering how the level of support within the community and improved practice could reduce the problem.

(2) Community Engagement Group

This group is chaired by a representative from YMCA Thames Gateway with other members representing 12 different voluntary and community sector organisations. The group has a key role in raising awareness of safeguarding within the local community and in educating the local community on the topic of safeguarding.

During 2016-17, the group met on 11th May 2016, 16th January 2017 and 27th March 2017. The meetings in 2017 focused on how the group can support the HSAB's Prevention Strategy (see Prevention Sub Group section below). This recognises that raising awareness of how to look for, and how to raise, a safeguarding concern amongst our staff, our partners and the wider public is central to preventing harm before it occurs.

Members of the group have participated in events with a view to raising safeguarding awareness such as mental health awareness week (16-20 May 2016), the Havering Show (August 2016) and provided input to Safeguarding Week (October 2016). The group has plans to continue this participation at similar events in 2017-18.

The group has reviewed their safeguarding information and organisations submitted their safeguarding policies for review by HSAB's Business Manager. Members of organisations on the group have attended various safeguarding training courses run by HSAB. The group has discussed on a confidential basis individual cases that raised safeguarding concerns and received helpful feedback from other group members. The group has provided feedback to the Council on its safeguarding web content and has helped design publicity, and suggested content for, the Safeguarding Week that is planned for October 2017. It is planned that a poster could be used by members of the group around the time of Safeguarding Week 2017 to highlight messages around the need to report safeguarding concerns, emphasising that safeguarding is everyone's business.

(3) Prevention Sub Group

A Prevention sub group was set up during the second half of the year to oversee the implementation of the Board's Prevention Strategy that was presented and agreed at Safeguarding Week (October 2016). The vision of the Prevention Strategy is for Havering residents to be able to live a life free from harm, where communities: have a culture that does not tolerate abuse; work together to prevent abuse and know what to do when abuse happens.

The role and purpose of the group will be to:

- monitor the implementation of the delivery plan in the Safeguarding Adults Prevention Strategy;
- review the Safeguarding Adults Prevention Strategy and keep it up to date; and
- foster a culture of taking action before harm occurs, by promoting access to information and education on how to prevent or stop abuse and neglect.

The group will sit under the Chairmanship of a member of NELFT's SMT and has representatives from the London Borough of Havering, Met Police, NELFT, BHRUT, CCG, London Fire Brigade and from a care home. The group will have its first meeting in 2017-18.

(4) Serious Case Review Group

This is a sub-group of both the HSAB and HSCB and has responsibility for making recommendations to the Chair about when to undertake a Serious Case Review (SCR) or a Safeguarding Adult Review (SAR).

As regards adult cases, the group met in April 2016 to consider a case of a young woman who took her own life in December 2015. All members of the group agreed that the case did not meet the criteria for a statutory SAR but recommended that the case was reviewed under non-statutory SAR

processes. This reflected that there was evidence that the case may support agencies to better understand how agencies work together to support adults especially when transitioning from children to adult services. The recommendation was accepted by the Chair of the HSAB and a SAR author (Professor Michael Preston-Shoot) was appointed and a SAR panel to oversee the review was established. Michael Preston-Shoot facilitated SAR learning events on 1st November 2016 and 7th December 2016 for practitioners to consider the issues raised by the case and areas where practice could be improved. Following these events, the SAR report, "The death of Ms A", was published (in June 2017) at: https://www.havering.gov.uk/downloads/download/532/adult_cases

The group considered another adult case in September 2016 that involved the death of an elderly man with care and support needs in a house fire. The group considered that the case met the criteria for SAR and the chair of the HSAB accepted this recommendation. This reflected that there was evidence that agencies could have worked together more effectively to provide fire prevention interventions and to understand his needs and plan his care. During 2017-18, a SAR author will be appointed and a SAR panel will be established to oversee the review.

In March 2017, the group received a SAR request referral concerning the death of an elderly lady with care and support needs where there was evidence to suggest that the personal care received was lacking and pressure ulcers were a contributory factor in her death. The case will be considered by the group during 2017-18.

The group also has responsibility for Domestic Homicide Reviews. However, during 2016-17, no cases were referred to the group for consideration as Domestic Homicide Reviews.

(5) Transitions sub group

The Transitions sub group supports both the HSAB and HSCB. The role and purpose of the group is to review current children to adult services transitions policies and procedures in health and local authority services and to audit compliance with existing policies and procedures, highlighting and sharing good practice initiatives and to disseminate learning from policy and practice reviews. The group is chaired by a member of NELFT's SMT and the vice chair is from the London Borough of Havering (Community Safety Team Leader).

In February 2017, the group organised a major Child to Adult Transition conference. Young people from the Sycamore Trust (a charity that aims to educate the community and empower individuals affected by Autistic Spectrum Disorders and/or Learning Difficulties) gave first-hand experience of the strengths and weaknesses of the support they received at various points of transition including primary education, secondary education, further education, employment and independent living. In addition, presentations by practitioners covered current legislation, policies and guidance that related to transition and workshops explored improvements that could be made around: how partners and agencies work together to improve transition, transition and safeguarding and involving service users effectively in making meaningful transitions. This event will be built on by the HSAB in 2017-18, with a major event on a similar theme planned for May 2017.

HSAB Risk Register

The HSAB risk register holds the areas identified by the Board as requiring oversight in order to progress actions quickly to reduce risks. The risk register is owned by the Executive and activity progressed through the working groups and operational board. The risk register is RAG rated to include impact of activities agreed to mitigate risk and is a standing agenda item at every HSAB group meeting and is used by the Independent chair to inform discussions held with the lead member and meetings with senior strategic leads from the partnership.

Annual Report

The HSAB publishes an Annual Report. The report is presented to the Havering H&WBB and Overview and Scrutiny by the Independent Chair. The report is sent electronically to MOPAC, Chief Executive and London Councils and held on the HSAB website.

Multi-agency training programme

During this period, Havering SAB conducted a training needs analysis to identify what current single agency training is being offered through the partnership in a bid to collaborate resources and reduce costs. The training sub group identified that although there were a number of similar courses on offer within each agency, the delivery of a number of their training courses was targeted at specific niche groups therefore making them available to a general safeguarding audience would not be suitable.

However, the group identified that basic introductory courses could be offered multi-agency and are currently exploring the possibility of creating an e-learning programme.

The Care Act 2014 statutory guidance was formally agreed in March 2016 and adopted within Havering. As a result the SAB held week long multi-agency briefing sessions to introduce the new guidance to those working and supporting adults. Self-neglect was formally recognised as a category of abuse within the Care Act for the first time. As a result the Board offered two full training courses on self-neglect and hoarding which was attended by a variety of multi-agency professionals working in adult safeguarding, health and provider settings.

HSAB Financial Contributions

HSAB is funded under arrangements set out in the Care Act. The contribution made by each member organisation is agreed locally. The member organisations' shared responsibilities for the discharge of the HSAB's functions include determining how the resources are provided to support it. Funding agreed for the past year was as follows:

Name of Agency	Contribution 16/17
Havering Council	£43,800
Police	£5,000
CCG	£10,284
BHRUT	£1,740
NELFT	£1,740
London Fire Brigade	£500
Total	**£63,064**

Staffing and support

Board staffing has remained relatively stable over the year. The full time business manager, Alice Peatling, moved to another role in October 2016. The board has been operating with an interim manager business manager (since February 2017), a training and development officer and an administrator to assist the board in achieving agreed priorities. The Board is chaired by an independent person and the Assistant Director of Policy, Performance and Community (**LBH)** acts as the vice chair.

Appendix: Summary of agency strengths and areas for development on safeguarding

1. London Borough of Havering (LBH)

LBH identified the following strengths and areas for development:

- The Corporate Plan reflects the Council's commitment to safeguarding and promoting wellbeing.
- The Corporate Competency Framework incorporates appropriate values and behaviours relating to safeguarding and there is a safeguarding clause within all Council job profiles and it's Code of Conduct. Contracts for commissioned services also contain explicit clauses that hold providers to account for preventing and dealing promptly and appropriately with abuse and neglect.
- The Council is well represented on the SAB and its subgroups and contributes significant resources (human and financial) to the work of the board.
- The Council is committed to the principles contained within "Making Safeguarding Personal" but further work is required to meet the Silver standard.
- A range of training is available to staff and partners but further work is needed to map training requirements against staff levels so that it is clearer to managers and staff what training is essential and what is discretionary.
- Advocacy arrangements need to be strengthened in some areas.

2. North East London Foundation Trust (NELFT)

In terms of Safeguarding adults, NELFT are proactive in protecting service users from abuse and neglect and our staff are well trained and supported in escalating safeguarding concerns to the local authority where abuse is suspected.

However, we recognise that there is always room for improvement and have identified several areas of concern:

- Ensuring consistency in access to Care Act compliant Safeguarding training for services commissioned by NELFT.
- MCA and DoLs training drop in compliance.
- An audit of electronic patient records found little evidence of seeking the views and desired outcomes of the service user during a safeguarding enquiry within the mental health setting.

3. Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)

BHRUT identified that safeguarding policies and procedures in place accessible to all staff and that there is evidence of collaborative working internally and with external partners to safeguard individuals.

The main areas for development are to strengthen the Trust's response to Making Safeguarding Personal and promote the use of advocacy services.

4. Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHRCCGs)

The CCG have a commissioning responsibility to ensure that the organisations we commission from have effective safeguarding arrangements in place and that the Government approved safeguarding principles are applied in terms of how we operate as an organisation and when working with our partners. The CCG has fulfilled our obligations and the NHS Outcomes Framework informs our plans especially for:

- Domain 4 - Ensuring people have a positive experience of care: and
- Domain 5 -Treating and caring for people in a safe environment and protecting them from avoidable harm.

The safeguarding team have continued to champion competency based learning for all staff and practitioners across the health system and reviewed and endorsed safeguarding training modules both within the CCGs, across primary care and with providers.

The effectiveness of the safeguarding system is assured and regulated by a number of bodies and mechanisms. These include:

- Provider internal assurance processes and Board accountability
- The Safeguarding Adult Board
- External regulation and inspection - CQC and Monitor (now NHS Improvement)
- Effective commissioning, procurement and contract monitoring.

All provider services are required to comply with the Care Quality Commission Essential Standards for Quality and Safety which include safeguarding standards (Standard 7).

The CCGs manage provider performance through formal contract review meetings using a contract monitoring risk framework. In addition, the following arrangements are in place to strengthen the CCGs' assurance processes:

- The Designated Adult Safeguarding Manager is a member of each main providers internal safeguarding committees.
- Joint commissioner/provider quality contract meetings always consider safeguarding issues and priorities and receive updates on the implementation of action plans from Safeguarding Adult Reviews/Domestic Homicide Reviews.
- Systematic reviews of serious untoward incident reports are routinely received from North East London Commissioning Support Unit (NELCSU) at the Quality and Safety Committee.

5. National Probation Service (NPS)

NPS staff are clear in terms of their responsibilities in relation to Adult Safeguarding. All front line staff receive mandatory training and Safeguarding audits form part of structured supervision and internal case audit activity. Further attention is required to improve the triangulation of learning from Domestic Homicide Reviews, Safeguarding Adult Reviews and internal audits to ensure that areas of concern and best practice are highlighted and appropriately disseminated to all staff.

NPS has identified clear safeguarding Adult protocols and policy to support all staff. There is a structure in place to support adult safeguarding practice with a lead identified amongst the practitioners, middle manager and senior manager.

NPS case recording systems have been developed to specifically record Safeguarding Adult concerns and this data is used to ensure prioritisation of resource and inform local performance monitoring and accountability.

Further attention is now required to ensure that this type of information is accurately recorded and reviewed. This will assist to highlight gaps in service delivery and the need for additional services and interventions. It will also reinforce NPS commitment to promote equality and highlight any evidence of inconsistent practice within the delivery of operational services.

6. London Fire Brigade (LFB)

Despite the Brigade's non-statutory status on local safeguarding adult boards, to demonstrate its commitment to safeguarding the Brigade has made a £1,000 voluntary contribution to each of the 32 safeguarding boards (shared with adults and children's safeguarding boards).

The Brigade is represented at the various pan London Safeguarding Boards and sub-groups, which provides an appropriate forum for sharing learning and participates in various local level meetings such as MARAC and High Risk Panels, which again facilitate appropriate sharing with our partners.

As a result of a recommendation from a Safeguarding Adult Review, the Brigade is delivering a pilot with the London Ambulance Service to provide Home Fire Safety Visits to high risk hoarders (as identified by the London Ambulance Service). An Information Sharing Agreement was signed by both the agencies before the pilot commenced.

In terms of areas of development, LFB is working to roll out safeguarding training to all personnel, will undertake the second part of the two-part auditing process by MOPAC, which will focus on adult safeguarding, and will aim to provide more regular feedback to SABs (via the Borough Commander) on progress made towards achieving safeguarding outcomes.