LONDON BOROUGH OF RICHMOND UPON THAMES

SAFEGUARDING ADULTS PARTNERSHIP BOARD

ANNUAL REPORT

APRIL 2012 TO MARCH 2013

Contents

1. FOREWORD

This is the 6th Annual Report of the London Borough of Richmond upon Thames Safeguarding Adults Partnership Board and it is pleasing to note once again that the Board continues to progress from strength to strength both in terms of its membership and its achievements.

As ever, the safeguarding of adults at risk remains at the centre of the Board's strategy and, in an era when the way in which public services are delivered is constantly under review and frequently subject to change, it remains crucial to ensure that safeguarding is a consistent core aspect of the work undertaken by all partner agencies and individuals working in adult health and social services and the wider community.

Last year's report was written at a time when the outcomes and recommendations of two Serious Case Reviews had been published; the clear message running through the findings is that it is imperative for us to communicate with each other and work together more effectively and thereby strengthen our ability to protect those at risk. Learning identified from the Serious Case Reviews is being embedded in practice through the action plans developed by the Board's Serious Case Review Sub-Group; this group will monitor that the plans are embraced and implemented operationally and strategically by all partners.

This year's report is written at a time when the Care and Support Bill, which has significant implications for Adult Social Care and for the legal status of this Board, is moving through the legislative process. In addition, the composition and legal status of primary care provision is also subject to change; the time of Primary Care Trusts has come to an end and Clinical Commissioning Groups came into being with effective from 1st April 2013. Going forward this will also impact on the way Deprivation of Liberty Safeguards under the 2005 Mental Capacity Act is managed by Local Authorities. Thus, as safeguarding adults at risk becomes further embedded in future policy and legislation, we are witnessing a far greater profile for adult safeguarding

During 2012-13 the Board underwent a self assessment audit to review the effectiveness of the Board in terms of its structures and processes, its membership and its accountability. The performance of all individual partners represented on the Board was also reviewed to assess how effectively safeguarding is embedded within their respective organisations. This process was supported by an external facilitator and the action plan emanating from the resultant findings has helped the Board identify its objectives for 2013-14.

Our strategic priorities for the coming year will focus on:

1. **Continuing to raise awareness** of safeguarding amongst professionals and staff across all sectors, with Service Users and with the public.

2. **Continuing to encourage Service User involvement** in the activities undertaken by the Board and across the Partnership, in order to improve Service User outcomes and ensure that the wishes of the Service User are taken into account at all times.

3. **Ensuring that robust policies and procedures are in place** to build on the learning outcomes of the Serious Case Reviews and further improve safeguarding practice between partner agencies and outcomes for Service Users.

4. **Strengthening the structures supporting the Board** ensuring that clear arrangements are in place to promote safeguarding and maintain transparency and accountability of both the Board and its partner members.

Some elements of the priorities identified above are, inevitably, a continuation of last year's objectives: we believe that this year's focus will take us further towards achieving our goals.

We both look forward to working with you in the year ahead to provide even greater support, through stronger partnership, adults at risk in our local communities.

Dawn Warwick, Chair of the LBRuT Safeguarding Adults Partnership Board

Cathy Kerr, Director of Adult and Community Services, LBRuT.

2. THE LANGUAGE OF SAFEGUARDING

'Safeguarding Adults' is the term given to the inter-agency systems that protect adults at risk from abuse, harm and/or exploitation.

This section provides a simple analysis of what safeguarding is about and illustrates the different aspects of safeguarding adults by way of case examples in which Adult Social Services and partner agencies have been involved over the past year.

2.1 Who is an adult at risk?

The Pan London Policy and Procedures define an 'adult at risk' as "an adult who is aged 18 or over "*who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation"*

This is consistent with the *No Secrets* definition and can include people with a learning disability, a mental health problem, older people or those with a physical or sensory disability. It may also include a person who may be vulnerable as a consequence of their particular personal situation such as experiencing domestic abuse, chronic illness, drug or alcohol problems, social or emotional problems, poverty or homelessness.

Case Example: Financial Abuse.

An older man with reduced mobility and a degree of cognitive impairment was supported to remain at home through regular visits from a carer employed by a domiciliary care agency. On one occasion the carer escorted the man to the bank to get a new bank card. The bank were already alert to the fact that transactions from the man's account had become increasingly irregular – with more money than usual being withdrawn via the ATM machine - and the cashier became suspicious at the carer's behaviour and over involvement. The cashier therefore called the Police, who responded immediately. LBRuT's Adult Community Services were contacted and, as a consequence of a safeguarding adults investigation, it became evident that the carer had been stealing from the man's account. The Police, the Bank, the man's Social Worker and an Independent Mental Capacity Advocate (IMCA) worked together thereafter, through the safeguarding process, to safeguard the man from further financial abuse. The carer was investigated by the Police and disciplined by the domiciliary agency.

2.2 What constitutes "Abuse"?

For the purpose of the Safeguarding Adults Policy and Procedures the term "abuse" is defined as "*a violation of an individual's human and civil rights by any other person or persons which results in significant harm*".

The Pan London Policy and Procedures, in line with the *No Secrets* Guidance, states that abuse can be viewed in terms of the following categories: physical, sexual, psychological/emotional, financial and material, neglect and acts of omission, discriminatory, institutional.

Many aspects of abusive behaviour may constitute a criminal offence and all suspected abuse must be investigated.

Case Example: Violence and Intimidation

A man with a long history of both mental health issues and alcohol dependence was detained by the Police under section 136 of the Mental Health Act (1983) having been found wandering the streets. Whilst at the Police station he revealed that he was afraid of two men who had previously robbed and assaulted him in his flat. He had invited the two men back for a drink after meeting them in a bar and whilst he was intoxicated they robbed and assaulted him. The Police investigated these allegations and the man was subsequently able to identify the two assailants. The Police arrested them and they were placed on remand awaiting trial at Crown Court. In the interim the Police referred the matter to Adult Community Services as a safeguarding matter and a safeguarding strategy meeting was called. The interim protection plan involved close liaison between Community Mental Health staff, local CID officers and Housing. The need to provide emergency temporary housing was considered given that the two perpetrators had threatened to harm the man further if he went to the Police. Victim Support was involved to provide general emotional and practical support and the Witness Support Service assisted the man in court. The perpetrators were found guilty and were sentenced to 8 years in prison.
Whilst the man did not attend any safeguarding meetings he had capacity to consent to the safeguarding process and he was informed of all actions; minutes, interim plans and his Protection Plan were shared with him. He has subsequently begun to engage in treatment programmes for alcohol misuse and dependence.

2.3 When and where does abuse happen?

It is everybody's right to live in a safe environment free from fear, intimidation or abuse. It is an unfortunate fact that abuse can happen <u>to</u> anyone, <u>by</u> anyone, <u>anywhere</u> and <u>at any time</u>.

Abusive actions may be deliberate but may also happen as a result of poor care practice, a lack of knowledge in how to support someone or ignorance. Media reporting and awareness raising campaigns have brought attention to acts of physical and sexual abuse. However, abuse can be more subtle: for example, when an adult at risk is persuaded to agree to something against their will, or taken advantage of because they do not fully understand the consequences of their choices or actions, or when their needs and well being are neglected.

Abuse can be a single act or repeated over time. Abuse can occur in any relationship, most frequently by people who the adult at risk knows.

Case example: Neglect and Acts of Omission

A carer within a residential Care Home was found to be administering her own medication to some of the residents in her care. The home manager raised a safeguarding alert with LBRuT Adult Community Services as soon as this fact was discovered and the carer was immediately dismissed.
Through the Protection Plan, agreed as part of the safeguarding process, LBRuT worked closely with the care home to ensure medication procedures within the Care Home were improved in order to safeguard against a similar situation happening again. Additional actions were implemented by the home, including ensuring that a consistent approach to medication was adopted on all floors within the home. The home provided updates on progress as part of the safeguarding process.

2.4 Reporting Abuse

Safeguarding Adults is everybody's business. Concerns that an adult at risk is being abused or is in danger of being abused should always be reported: see section 6 above for contact details. If the adult at risk is in serious danger then the Police / emergency services should be contacted via 999.

Case Example: Partnership Working

A married couple, well known to LBRuT's Learning Disability Services, live independently with minimal support. Both are in full time, supported employment. The couple use a local bank for all their money-management and are well known in the branch and are supported to pay bills. They are usually served by the same bank-employee but on one occasion, when this employee was away, they were served by another employee who noticed irregularities with their account. This led to an immediate internal investigation which indicated that the bank-employee they usually dealt with had committed significant fraud. The bank supported the couple to contact the Police to report this. The police then raised a Safeguarding Alert with LBRuT Learning Disability Services.
The Police investigated the alleged fraud over a period of almost 1 year. Throughout the investigation, a named Detective Constable (DC) from the Metropolitan Police worked in partnership with the LBRuT Social Worker in supporting the couple,

including ensuring that they were aware of potential court appearances. The DC attended regular Safeguarding meetings which had a very positive impact on the overall planning of the support provided to the couple. Similarly, the Social Worker supported the DC when the police required further information from the couple, or when there was a need to relay information to them, in order to ensure they fully understood what was happening.
The couple received additional support while the Safeguarding process was on-going as a significant amount of money had been stolen which resulted in serious financial problems for them. Through this support the couple were able to re-gain confidence in their own abilities and also learn new skills to enable them to have more control over their finances and so avoid financial abuse being as much of a risk in future.
The bank refunded the full amount of money taken (plus compensation) and the perpetrator eventually pleaded guilty and was given a custodial sentence. The couple are very happy with the outcome and felt very supported and informed throughout the Safeguarding process.

2.5 Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) are in addition to - but do not replace - other safeguards in the Mental Capacity Act 2005. The Deprivation of Liberty Safeguards are solely about ensuring that there are appropriate safeguards in place when it is deemed that a person, who lacks the capacity to decide the matter for themselves, needs to receive care or treatment, in their best interests, in a hospital or care home, in circumstances that deprive them of their liberty. Every effort should be made, in both commissioning and providing care and treatment, to prevent deprivation of liberty. If deprivation of liberty cannot be avoided, it should be for no longer than is necessary. (See also page 39-42)

Case Example: Deprivation of Liberty Safeguards

An “Urgent Authorisation” request was received under the Deprivation of Liberty Safeguards (DoLS) for an elderly woman with dementia who had recently moved from hospital into residential care. The had taken place at the instigation of her daughter who held a Health & Welfare Power of Attorney in respect of her mother: the daughter felt it was not safe for her mother to return home primarily because she would not allow carers’ access in order to provide the level of support she needed. Social Care professionals involved shared the daughter’s opinion: prior to being admitted to hospital the elderly woman had become malnourished and increasingly confused as she was not eating or taking her medication. The front door to the Care Home had to be locked as there were concerns the woman may abscond from the premises; as a consequence she repeatedly told visitors that she had been imprisoned and was being kept in the home against her will. In response to the woman’s constant demands to return home, which was making her very agitated and distressed, the Care Home granted themselves an Urgent Authorisation. At the same

time, as required under the law relating to DoLS, the Care Home also submitted a request for a Standard Authorisation to LBRuT's DoLS Team. A Best Interest Assessment was completed in response to the home's request and it was agreed that in the short term it was in her best interest to remain living in the Care Home. Authorisation was therefore granted for one month only with a condition attached that stated that all least restrictive alternatives to manage the woman's care needs were explored. Through discussions with the daughter it was agreed to introduce 24 hour live-in carer which would enable her mother to return home. Within 3 months a suitable care provider had been identified and all necessary arrangements made to facilitate the elderly woman's return home. There have been no issues around non-compliance with the live-in carer since she returned home and both mother and daughter are happy with the outcome.

3. THE WORK OF THE BOARD

The Department of Health *No Secrets* Guidance (2000)[1], issued under Section 7 of the Local Authority and Social Services Act (1970), places a responsibility on three key statutory agencies (Health, Local Authorities and the Police) to work together, in partnership, to ensure that systems, policies and procedures are in place to safeguard adults at risk.

The Guidance also recommends that partners establish appropriate multi-agency governance arrangements and produce an annual report to both monitor and evidence how this responsibility is being enacted. In the London Borough of Richmond upon Thames the Safeguarding Adults Partnership Board (SAPB) has responsibility for implementing the *No Secrets* requirements and the detail of its work is built upon a national framework of standards produced by the Association of Directors of Adult Social Services (ADASS) in 2005[2]. The Board co-ordinates local partnership arrangements to safeguard adults from harm and continues to implement and maintain the consistent, cohesive partnership working required by the Pan London Policy and Procedures[3] which were launched in September 2011.

The aim of this report is to outline the work of the Board during 2011–2012. It contains contributions from its member agencies and describes all the activity carried out by the partner organisations represented on the Board.

4. A YEAR IN REVIEW

Much has happened during the previous twelve months in relation to the work of the Board. The following are worthy of specific mention:

- Activity levels in Safeguarding Adults continue to increase and reflect an ever increasing awareness of adult safeguarding amongst organisations and the wider community (See Section 9).

- Learning from two Serious Case Reviews has been translated into an action plan for improving safeguarding practice both strategically and operationally that is currently being implemented (See Section 7).

- We welcomed a representative from the London Probation Service and LBRuT Housing.
- The Board underwent a self assessment exercise and as a consequence identified how it might strengthen its governance arrangements and its membership and thereby enhance its effectiveness and performance as a Board.

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1 No Secrets: No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse

2 Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work

3 Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse

- The Board also set its priorities going for 2013 -2014, based on the findings of the self assessment, from which the Board's business plan will be developed.
- Preparations were made in relation to Clinical Commissioning Groups superseding Primary Care Trusts in terms of ensuring continuity of membership of the Board.
- Links with the incoming Health & Wellbeing Board were developed.

The work of the Board is based on the Pan London Policy and Procedure and the principles of empowerment, prevention, protection, proportionality, partnership and accountability identified by the Coalition Government in May 2011, which, together with the Care and Support Bill (2013), will continue to shape the work of Board going forward.

5. STATEMENT OF COMMITMENT

The core aims of the SAPB remain constant: members of the Board are committed to working together to safeguard adults at risk, to work towards preventing abuse and to achieving an appropriate level of response when abuse has, or may have, happened. Going forward, the Board's proposed new Terms of Reference will include a statement of commitment and a confidentiality clause that all members will sign up to. (see Appendix 1)

This report reflects the level of commitment and activity undertaken to train staff, to raise awareness within the community, to support front line staff in the effective investigation of allegations of abuse and to co-ordinate the response to issues of abuse in a way that protects, involves and empowers the adult at risk.

Individual Board Members have made specific commitments in their proposed actions (see pages 61-69).

5.1 Membership and Responsibilities

The London Borough of Richmond upon Thames Safeguarding Adults Board has strategic leadership of safeguarding across the Borough. The Board holds all agencies to account in order to:

- improve the way local agencies and services work together;
- protect, involve and empower those at risk from harm or abuse;
- learn lessons from situations when things have not gone well and improve our practice as a result.

The Board endeavours to maintain a positive approach to safeguarding that sends out a clear message to the local community and promotes the Board's intention to safeguard and empower adults at risk to stay safe.

The Board is the multi-agency body providing strategic leadership for agencies providing services to vulnerable adults and seeks to ensure a consistently high standard of professional response to situations of abuse. As such the Board oversees how organisations across the Borough of Richmond work together to safeguard and protect vulnerable adults who may be at risk of harm or who have been abused or harmed.

The Board meets on a quarterly basis, although extra-ordinary meetings can be called when necessary, with a defined sub-group structure.

The five main areas of operation, as outlined in the Board's Annual Report 2011-12, remain unchanged and continue to provide an effective means of decreasing the risk of abuse, namely:

- Promoting the message of awareness amongst staff and the public to increase knowledge and confidence in reporting concerns
- Ensuring staff are fully trained and understand their roles and responsibilities in recognising, reporting and investigating abusive practice
- Developing policy and standards of best practice for staff and care providers to follow
- Screening out and preventing potential abusers coming into contact with adults at risk through robust employment practices
- Auditing the work of partners on a regular basis to ensure that effective systems are in place.

Membership of the Board has strengthened during the past year and has moved a long way towards achieving appropriate representation at a strategic level from those agencies who commission services, those with statutory duties to adults at risk and those with operational responsibility for service provision.

Following the self assessment exercise the Board has refreshed its Terms of Reference which now include a statement of commitment and a confidentiality clause. (See Appendix 1)

5.2 Accountability

To date the Board has reported to the Local Strategic Partnership (Richmond Partnership Executive). Now that the Richmond Health & Wellbeing Board is established and operating on a statutory footing the proposed Terms of Reference for the Board indicate a stronger link with the Health and Wellbeing Board going forward. The Board also provides reports to the Community Safety Partnership Board and the London Borough of Richmond upon Thames Council's Health, Housing and Adult Services Overview & Scrutiny Committee.

Each of the statutory partners has their own internal reporting mechanisms, including the submission of annual progress reports and this report will feed into those processes.

The reciprocal chairing arrangement with Wandsworth lends the Board an additional aspect of objectivity and governance

The Board currently has three sub-groups, one of which leads on Learning and Development across all partners, one on Policy and Performance across partner agencies and the third, the Serious Case Review Sub-Group, co-ordinates the response to and learning from serious incidents involving any adult living within the Borough.

6. CONTACT POINTS

REPORTING A SAFEGUARDING CONCERN

For specific information on Safeguarding in the Borough please look at the London Borough of Richmond-upon Thames website at:

http://www.richmond.gov.uk/adult_protection

During Office Hours:

Safeguarding alerts and general safeguarding concerns should be raised via the Council's Access Team on: **0208 891 7971**

Out of office Hours:

Via The Adults Emergency Duty team on: **0208 744 2442**

Remember that in an emergency - you should always call the Police or Emergency Services on: 999

DEPRIVATION OF LIBERTY SAFEGUARDS – REPORTING AND ADVICE

Deprivation of Liberty Safeguard (DoLS) issues are managed directly by the Safeguarding Team.

They can be registered or reported to the **Safeguarding Adult/DoLS Team** on **020 8831 6337 Fax: 0800 014 8629**

7. Serious Case Reviews

7.1 OVERVIEW

The Serious Case Review (SCR) Sub-Group was established as a sub-group of the Safeguarding Adults Partnership Board (SAPB) in 2011 and met on 5 occasions in the year from April 1st 2012 to March 31st 2013. The role of the SCR Sub-Group is to identify learning from Serious Case Reviews, draw up relevant action plans on behalf of the Board to address recommendations made in SCR reports and provide assurance to the Board as to progress made in implementing those action plans. Serious Case Reviews are initiated when a vulnerable individual has come to serious harm, or in some cases has resulted in the death of an individual, where there are concerns about the care they received.

The SAPB has a leadership role to promote, and to have oversight of, care provided to vulnerable individuals and to highlight where it has specific concerns. Compliance with all legal processes, statutory requirements, regulated activities, best practice and ensuring a competent workforce are the responsibilities of individual agencies. There is also a clear responsibility on commissioners of services to ensure services they commission are of an appropriate standard and have in place processes to monitor such arrangements.

The SCR Sub-Group has a key role in managing the process of investigating serious incidents, reporting at each SAPB meeting and bringing to the Board's attention any issues of concern, issues of interest and when ever actions are completed. The SCR Sub-Group also monitors the work that has been undertaken by individual agencies in addressing identified areas of service improvement.

As part of the process of developing the SCR report when a SCR has been commissioned by the Board, in each instance the relevant agencies complete an Individual Management Report (IMR), which is then used to formulate both the overall SCR report and recommendations which lead to a more detailed set of actions.

During the period April 2012 to March 2013, there were 2 Serious Case Reviews commissioned by the SAPB and the relevant actions that followed from those SCRs led by the SCR Sub-Group, are detailed below.

7.2 First Serious Case Review

The first Serious Case Review concerned an elderly man who died in hospital following admission from a Care Home.

There were 12 recommendations arising from the SCR report which was produced in November 2012 by an independent chair and discussed at a meeting of the SCR Sub Group in November 2012. The learning and actions that followed were included

in an Action Plan that was subsequently presented and approved by the SAPB in 2011. The recommendations from this SCR are detailed below.

7.2.1 Recommendations and Learning:

Recommendation from the first SCR fall into the following 4 main categories, with examples included below:

(1) Information Exchange

- *Upon an individual's discharge from hospital a copy of the hospital Discharge Summary is provided for those involved in follow up care.*
- *Where there has been a further significant event, any previous assessment for residential or nursing care must be reviewed to ensure it takes account of the significant event.*

(2) Process & Protocol

- *Pre-admission to hospital assessment procedure is amended specifically include self monitoring arrangements, and a check is carried out to ensure that the equipment is available for the person to use.*
- *Where a person is known to self monitor, this is identified in the care plan with suitable reminders incorporated into the care plan.*
- *Care homes will revise guidance to staff about when they refer residents to the visiting GP.*
- *Escalation procedures are established when information requests in regard to Safeguarding investigations are not being responded to within a reasonable time.*
- *A protocol is developed for responding to allegations of Institutional Abuse.*
- *Internal protocols for raising safeguarding adult alerts to ensure that significant time delay do not occur should be reviewed*

(3) Practice Issues (Providers and Commissioners)

- *Consultations with the GP- and other clinicians where appropriate - must be carried out in private.*
- *Care provider staff are trained in relation to diabetic care.*
- *Staff in care home settings must respond to emergency situations expeditiously and a training needs analysis carried out with staff to prepare them to better respond to emergencies.*

(4) Plans & Further Action

An Improvement Plan for addressing the issues identified is produced, including timescales for completion, against which the SAPB can measure progress.

7.3 Second Serious Case Review

The second Serious Case Review concerned a woman who died in a psychiatric hospital having been transferred from the Accident and Emergency Department of a local hospital.

The SCR Sub Group met on February 18th 2013 to consider an initial presentation from the Independent Chair on her report into the serious case review. An Executive Summary and the full report were considered by the Sub Group and an initial action plan was produced by the sub group to address the recommendations in the Independent Chair's report which provided a comprehensive story relating to the events and the lead up to the woman's subsequent death.

The SCR Sub Group noted the work that had been undertaken by the two NHS Trusts involved in addressing identified areas of service improvement immediately following the death as set out in Composite Action Plans the NHS Trusts produced.

The SCR Sub Group at its meeting on February 18th, proposed two additional recommendations to those proposed in the Independent Chair's initial report in response to issues that had been raised in the report, resulting in 11 recommendations in total that were considered and subsequently agreed by the SAPB on February 28th 2013.

7.3.1 Recommendations and Learning

Recommendation from the second SCR fall into the following 3 main categories, with examples included below:

(1) Information Exchange

- *A definitive shared protocol is developed by the two NHS Trusts for transfer of patient information between their two organisations.*
- *An audit is carried out of communications between the Home Treatment Team and the relevant hospital ward during the relevant period.*

(2) Practice Issues (Providers and Commissioners)

- *Training and guidance is provided to relevant staff about the interaction between the Mental Health Act, the Mental Capacity Act and the Safeguarding Adults procedures.*
- *Joint work is undertaken on the Approved Mental Health Practitioner service and in particular on its implications for safeguarding policy and practice.*
- *The application of the Mental Capacity Act by all partner agencies is regularly reviewed by the Safeguarding Adults Partnership Board.*
- *Safeguarding issues are fully integrated into regular staff supervision across all partner agencies.*
- *Risk assessments are appropriately updated and routinely accessed to inform continuing care and management.*
- *Liaison psychiatry services including the care pathway for adults with mental illness and risky behaviour undergo a review.*
- *Scrutiny is undertaken of safeguarding arrangements and practices on the ground; including assurances around the practices of frontline staff and managers.*

(3) Plans & Further Action

- *Action plans are prepared by the two NHS Trusts involved to demonstrate that the identified necessary improvements have been made and that the commissioners of the two Trusts' services have also satisfied themselves about the changes made.*
- *Any specific actions relating to the Serious Case Review are identified and reported back to the SAPB.*

The recommendations detailed above have formed the basis of the Sub Group's work plan going into 2013/14 and an action plan for implementation was subsequently agreed by the Board at its meeting on May 23rd 2013.

7.4 Progress Update

The action plan for implementing the recommendations of the Serious Case Reviews was adopted towards the end of 2012-13. Going forward into 2013-14 the following actions have been implemented:

1. New training has been commissioned to clarify the interface between the Mental Health Act, the Mental Capacity Act and safeguarding Adults. Thereafter staff will have a greater understanding of relevant legal and policy leading to robust decision making that in turn will enhance Service User safety.

2. Effective communication was identified as the cornerstone of good practice and key to ensuring Service User safety. All agencies have now reviewed how they share information with internal and external partners to improve information sharing and communication is achieved in future.

3. Guidance has been developed for staff in all agencies reiterating a) what action must be taken when institutional abuse is suspected or alleged and b) who to inform if the robustness of the Safeguarding investigation is jeopardised because key agencies do not attend Safeguarding meetings.

8. SAFEGUARDING ACTIVITY

This section of the report provides information on safeguarding activity during the 2012 -13 financial year and covers the following themes:

- Information on alerts[4] and referrals[5]
- Demographic information on people with a safeguarding referral.
- Locations of alleged abuse, types of alleged abuse and relationships of the people alleged to have caused harm
- Case conclusions and outcomes for the adults at risk and for people alleged to have caused harm
- Care Home and Homecare Providers
- Performance data relating to PLP timescales
- Deprivation of Liberty Safeguards (DoLS)

This section also includes "Comment", at the end of each sub-section, which provide some observations on the findings reported and, where appropriate, action we are taking as a result.

8.1 Number of alerts and referrals

There were 845 alerts were received in 2012-13, averaging 70 alerts per month. This represents an 11% increase from 2011-12 when 759 alerts were received.

It is generally expected that alerts will increase year on year as safeguarding adults work becomes progressively more embedded within professional practice and public consciousness is heightened.

There has been a significant increase in the number of alerts for older people of 25.5% from 444 in 2011-12 to 557 in 2012-13. In particular there has been a significant rise in the number of alerts raised in 2012-13 compared to 2011-12 by:

- Secondary Health Staff: 12.6% (70 compared to 45 in 2011-12)
- Family Members 12.4% (69 compared to 52 in 2011-12)
- Domiciliary Staff: 11.9% (66 compared to 53 in 2011-12)
- Residential Care Staff: 9.9% (55 compared to 38 in 2011-12)

Comment: *This can, in part, be attributed to a raised level of awareness following last year's annual report and the refreshed publicity material for safeguarding. It is also likely that it is a consequence of the heightened and repeated media publicity following exposure of the Winterbourne View scandal.*

4 An **alert** is when any safeguarding issue is first raised with Adult Social Care Services from any source.

5 After an alert is initially received it is reviewed, considered and risk assessed. The matter will then either be dealt with through another route (as it is not considered to be a safeguarding matter) or it will advance to the next stage of the safeguarding process for fuller investigation and formal intervention. This is called a **referral.**

TABLE 1: Alerts, referrals & % of alerts progressing to referral over last 3 years

YEAR	Alerts	Referrals	% Alerts that progressed to referral
2010/11	438	154	35%
2011/12	759	232	31%
2012/13	845	328	39%

Of the 845 alerts received in 2012-13, 328 (39%) progressed to referral; a much higher proportion than in the previous year. There were 96 more referrals in 2012-13 – a significant increase and equates to an average of 27 referrals being received per month.

Comment: *This increase is a positive development and indicates that the appropriateness of alerts received is increasing. This reflects the work of the Safeguarding Adults Team in working with partner agencies and also their raised profile in Provider Forums.*

It also dovetails with the internal work of the Safeguarding Adults Team in terms of: (1) closer working within individual Adult Community Services Teams and the introduction of Safeguarding Surgeries; (2) the work of the Best Practice Group - where detailed discussion of learning points emerging from safeguarding cases is facilitated; (3) the Safeguarding Adults Managers Performance Group - where overall performance is discussed and analysed in terms of improvement needed.

Of the alerts progressing to referral, 20 were for people receiving direct payments, which is an increase on the 13 alerts received in 2011-12. There was also a small increase in referrals for people who fund their own care - 56 in 2012-13 compared to 50 in the previous year.

Comment: *Recording in the last financial year improved information around people who fund their own care as this is now a mandatory part of our social work recording system and a continuing increase in this field is reassuring.*

It should also be noted that by expanding the breadth of safeguarding awareness and intelligence we are now capturing more alerts/referrals for people who fund their own care – many of whom are resident in care homes.

During 2012-13, 98 service users were the subject of more than one alert that progressed to a referral (a repeat referral). This is significantly more than the previous year when there were 16 repeat referrals. The majority of the repeat referrals in 2012-13 were for older people (55%, 54) and adults with mental health problems (17%, 17).

Comment: *We are currently investigating this increased trend in repeat referrals. Reasons for repeat referrals have primarily been identified as:*

- *Capacitated adults who initially agree to proceed with a safeguarding investigation but subsequently change their mind so the process is closed down. Concerns then resurface at a later date which triggers another referral – which is again investigated as far as the Adult at Risk wishes.*
- *Evidence of different allegations being made in relation to the same Adult at Risk being received in close succession which require separate investigations.*
- *Repeat allegations made by Adults at Risk who have advancing dementia and confusion which need to be followed up as and when they are raised. It is appropriate in such circumstances that each allegation is investigated appropriately and closed down as soon as it is safe to do so.*
- *Recording errors; this will be picked up by the Head of Safeguarding in "Safeguarding Performance Management" meetings and also monitored within individual care teams.*

Figure 1 shows alerts categorised by people group. 'Other Adults at Risk' refers to people from other local authorities and carers.

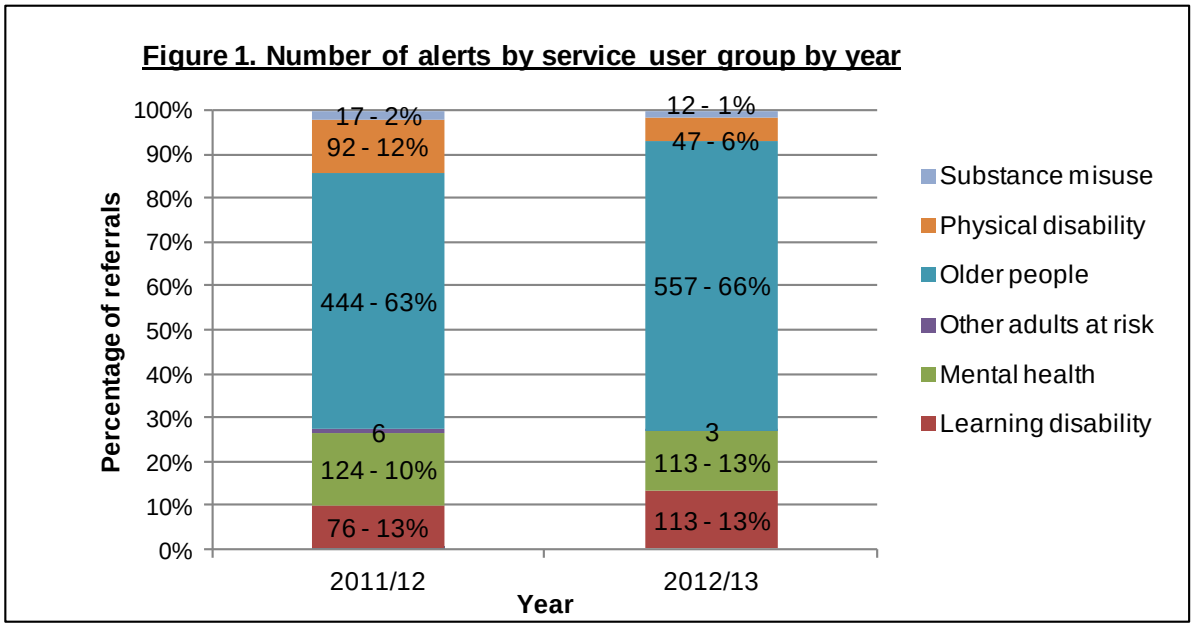
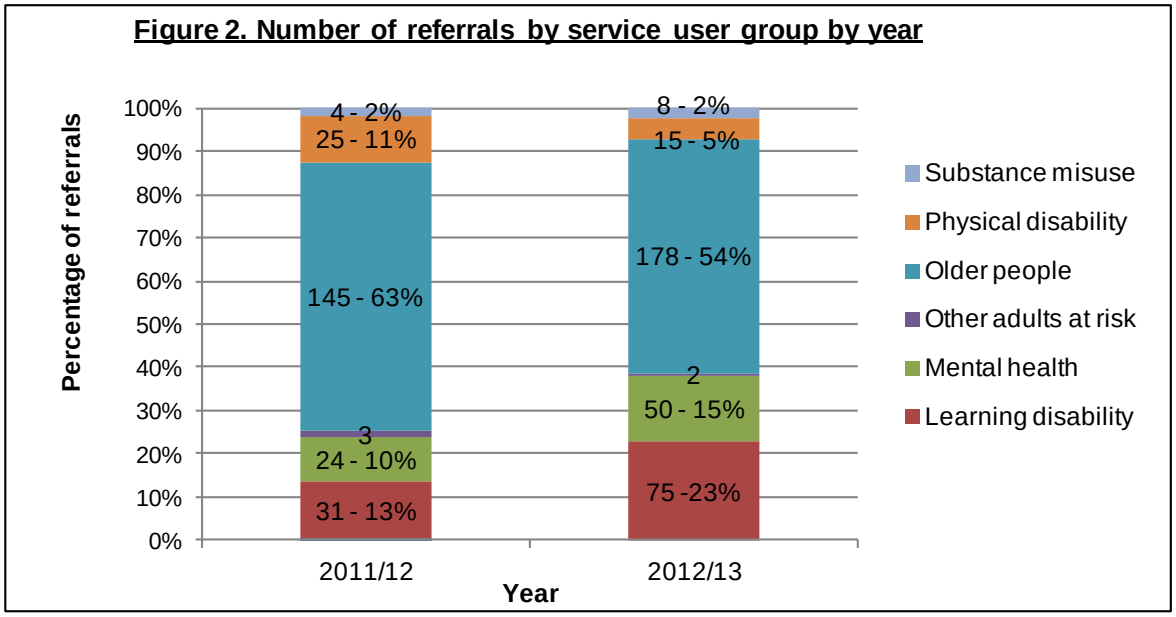


Figure 2 shows referrals categorised by people group. A significant proportion of alerts for adults with a learning disability progressed to referral.

Comment: *this can, in part, be explained by the fact that we have changed the way we collect this data[6]. This will be monitored going forward but it is anticipated that the rise will be less significant next year.*

[6] Learning disability service users aged 65+ are counted in the learning disability category in this report. In the previous 2011/12 Annual Report they were counted in the older people category.



8.2 Demographics of people with referrals

Gender, age group, and ethnicity of the people with safeguarding referrals provide key information about our safeguarding work. The following provides an overview of 2012-13 safeguarding referrals by this demographic information and highlights key issues of note.

Gender: Two thirds (66%) of referrals were for females (217 people). This is similar to the proportion of referrals received in 2011-12 (64% female) and is higher than the national profile for safeguarding referrals (with 61% of referrals received nationally in 2011/12 being for females)[7]. See Table 2 below.

***Comment**: whilst it is difficult to measure differentiations between levels of female versus male alerts/referrals, we do know that 37% (9,434 out of 25,296) of older people aged 65 and over are living alone in the Borough of Richmond (compared with 31% London-wide) and that the majority of those that live alone are female.*

We recognise that social isolation is an issue for the Borough and evidence indicates that the combination of being alone, elderly, socially isolated and female heightens vulnerability to abuse.

To address the above as an issue going forward we will continue to ensure:

- *That the above information is brought to the attention of the Richmond MARAC (the Multi-Agency Risk Assessment Conference responsible for co-ordinating the response to domestic abuse within the Borough);*
- *That this information is also brought to the attention of the Community Safety Partnership;*
- *Awareness of this issue – and the range of appropriate interventions/responses – is raised through training.*

[7] Source: NHS IC Abuse of Vulnerable Adults Statistics 2011/12

TABLE 2: Referrals by gender

GENDER	REFERRALS	
	Number	Percentage
Male	111	34%
Female	217	66%
Total	328	100%

Age: The safeguarding referrals were distributed across all age bands, with the highest proportion being for the 85+ age band (33%, 109 people). This compares to 31% in the 85+ age group in 2011/12. In comparison to 2011-12 there was also a decrease in referrals for people aged 75-84, from 19% in 11/12 to 11% in 2012-13, and an increase in referrals for people in the 45-64 age group from 17% in 11-12 to 20% in 12-13 due to an increase in referrals for adults with a learning disability.

Comment: *nationally there was a lower proportion of referrals for the 85+ age group (25%), compared to the proportion for this age group in Richmond (33%). The higher proportion of referrals for this age group in Richmond may reflect the high proportion of older people aged 85+ in the Richmond population as a whole.*

The older people become the more likely they are to receive care. Thus the high proportion of alerts/referrals for older people is reflective of the higher number of people receiving services. This is not disproportionate, nor is it unexpected. Although this figure has reduced year on year it is still the highest category for alerts/referrals.

We have recently refreshed the public information we have available and will ensure that we specifically target this age band.

We will ensure, in keeping with our response to the information relating to referrals for females that this information is brought to the attention of the Community Safety Partnership and that awareness is raised through training.

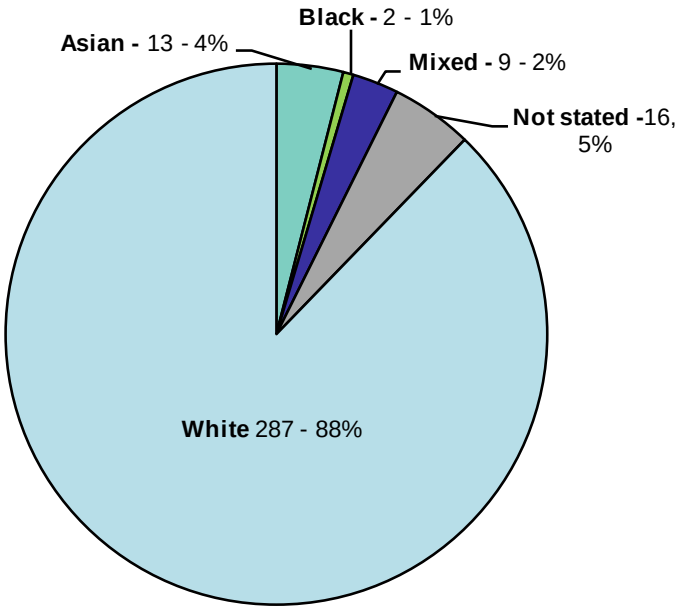
TABLE 3: Referrals by age band

AGE BAND	REFERRALS	
	Number	Percentage
18-30	45	14%
31-44	33	10%
45-64	64	20%
65-74	41	12%
75-84	36	11%
85+	109	33%
Total	328	100%

Ethnicity: 88% (287) of the safeguarding referrals were for people from White (British and other White) ethnic groups. 7% (25) of referrals were for people from BME backgrounds. This reflects the Adults and Community Services service user group as a whole, which is 6% BME.

The other 5% of referrals were for people for whom ethnicity was either not recorded (14) or was recorded as 'not stated' (2).

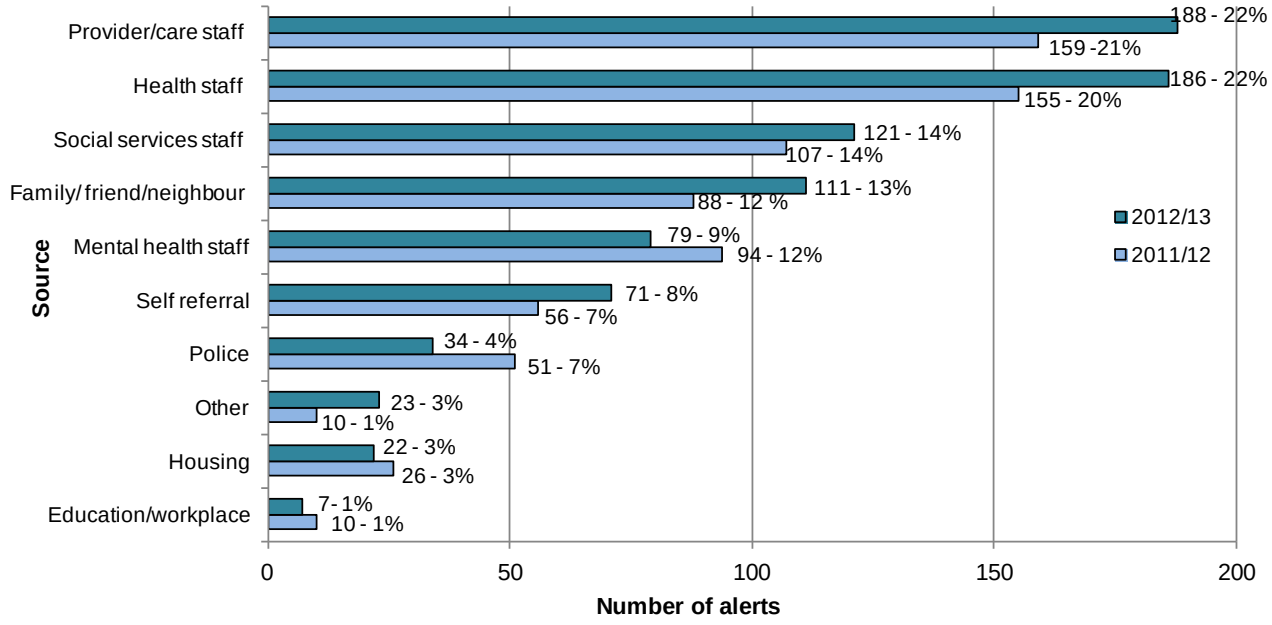
Figure 3. Referrals by ethnicity - 2012/13



8.3 Source of alerts

The highest proportion of alerts in 2012-13 was received from provider staff working in care homes or providing home care services (22%, 188) and primary/secondary health staff (22%, 186).

Figure 7. Number of alerts by source of alert by year



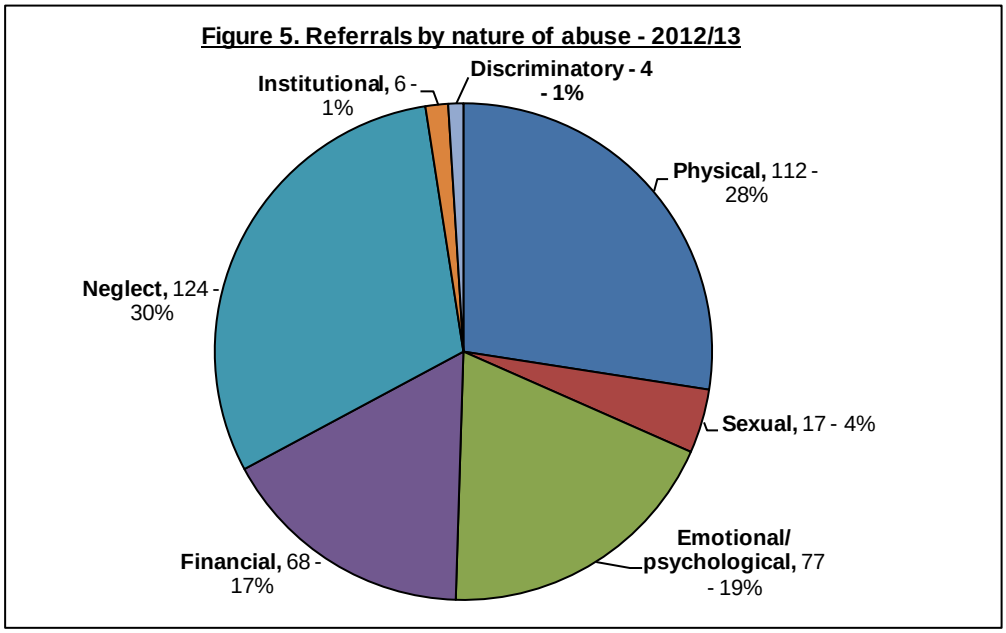
Comment: *This reflects the robust links that exist between provider services and LBRuT's Workforce Development Team, primarily through the Board's Learning and Development Sub-Group; greater attendance at and access to training has heightened awareness of both safeguarding issues and how to appropriately report concerns. It also reflects closer working between the Safeguarding Team and Workforce Development to improve the quality of training being provided and further reflects the close working relationship between the Safeguarding Team the Quality Assurance Team, including an increased profile at Care Provider Forums.*

Training was clearly identified as an area of focus in the outcomes of both Serious Case Reviews and, going forward, training is one of the 4 key priorities identified for the Board during 2013-14.

8.4 Nature of abuse for safeguarding referrals

Some referrals included more than one allegation and/or more than one type of alleged abuse. Therefore the number of allegations and types of abuse is higher than the number of referrals. There were 449 allegations for the 328 referrals received.

The chart below shows referrals by the nature of alleged abuse.



8.4.1 Nature of abuse for all referrals

The most common types of alleged abuse across all referrals were neglect – 28% (126 people) and physical abuse – 27% (120). 20% (88) of alleged abuse was emotional/ psychological and 17% was financial (75). 4% (28) of alleged abuse was sexual abuse, 1% (6) was institutional and 1% (6) was discriminatory abuse. A high proportion of the figures for neglect relate to safeguarding in relation to provider care which was dominant last year. In contrast financial abuse, which was previously a dominant reason for abuse has comparatively reduced.

Comment: *the above is reflective of the national picture with "neglect" and "physical abuse" being the most prevalent forms of abuse. Within LBRuT the reduction in financial abuse can, in part, be attributed to a heightened awareness and recognition of this type of abuse, particularly by LBRuT staff and the Police.*

8.4.2 Nature of alleged abuse for older people

The most common types of abuse were neglect - 38% (95 people) and physical abuse - 26% (65 people). 17% (41 people) was financial and 16% (40 people) was emotional/ psychological[8].

[8] Referrals for categories of abuse such as discriminatory or institutional are not included in this analysis where the number of referrals within each service user group is less than 5.

8.4.3 Nature of alleged abuse for adults with a learning disability

The highest proportions were for neglect - 29% (21 people), physical – 28% (20 people). 21% emotional/psychological (15 people) 11% (8 people) was financial and 8% (6 people) was sexual abuse.[9]

8.4.4 Nature of alleged abuse for adults with mental health problems

The most common types of alleged abuse were physical – 29% (16 people), emotional /psychological - 27% (15 people) and financial – 26% (13 people). A further 16% of alleged abuse was sexual abuse - 16% (9).

8.4.5 Nature of alleged abuse for adults with a physical disability

The highest proportions of allegations were for emotional/ psychological abuse - 29% (14 people) and financial - 25% (12 people). 16% (8) of abuse was physical and 16% (8) was sexual. A further 12% (6) referrals were for neglect.

8.6 Location of abuse for referrals

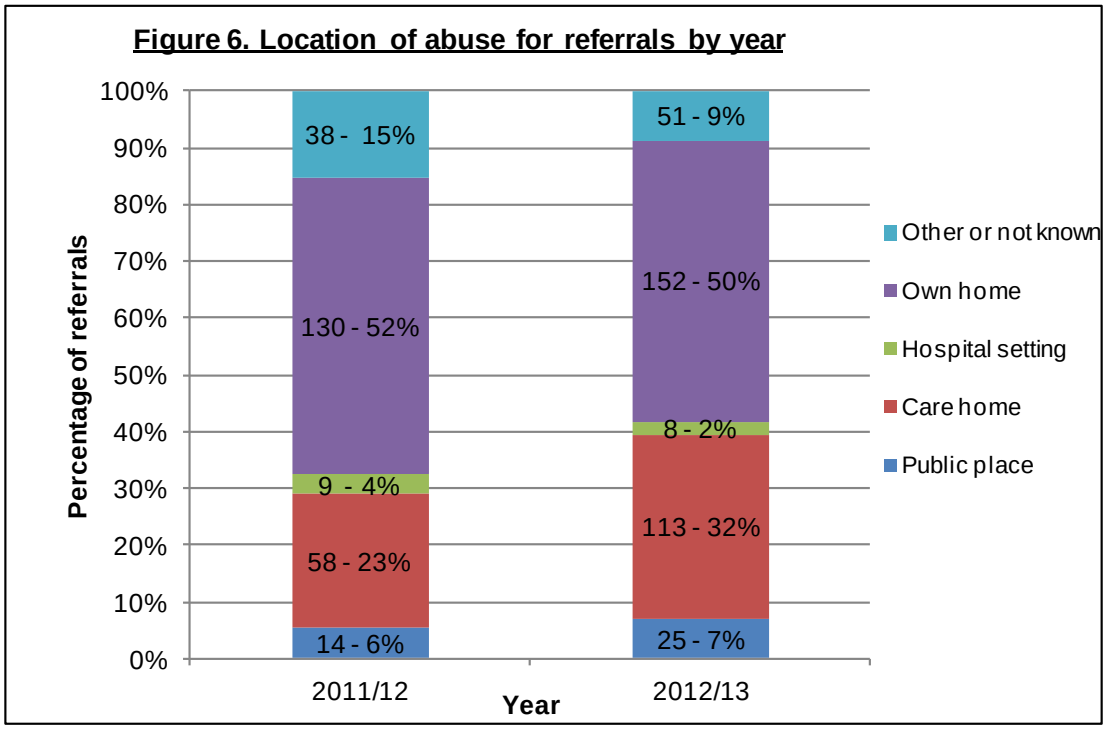
The most common locations of alleged abuse in 2012-13 were the person's own homes (44%, 152 people).

Comment: *this reflects the national trend, with the most common location of alleged abuse nationally also being peoples' own homes[10]. This in itself reflects increased awareness of abuse within care settings and is a pleasing indication of an increased willingness on the part of care service providers to report suspected abuse. Within LBRuT 32% of alleged abuse (113 people) was flagged as occurring within a care home setting: this indicates an increased awareness of safeguarding practice within care home settings and is a reflection of the increased involvement of the Safeguarding Adults Team at Care Provider Forums.*

Smaller proportions of alleged abuse took place in public places (7%, 25 people), hospital settings (2%, 8 people) and other or unknown locations (15%, 51 people). This shows a 9% increase in care homes and a 2% decrease in the person's own home as locations of abuse compared to 2011/12.

For more information on provider performance, see section 8.9 on page 35.

9 & 10 Abuse of Vulnerable Adults in England 2011-12, Final Report,



8.7 Relationship of person alleged to have caused harm

The majority of people alleged to have caused harm were care workers or family members of the adult at risk.

Care workers were the largest group of people alleged to have caused harm at 37% (residential care - 22%, homecare care - 13%, and other health care workers - 2%). Family, friends and neighbours were just below this group at 34% (family - 15%, neighbours /friends - 10%, partners - 9%).

In comparison to 2011-12 there was an increase in the proportion of residential care workers as person alleged to have caused harm from 16% to 22%. This is related to the increase in allegations where the locations of abuse were care homes.

There was a decrease in other family members alleged to have caused harm, from 19% in 2011-12 to 15%.

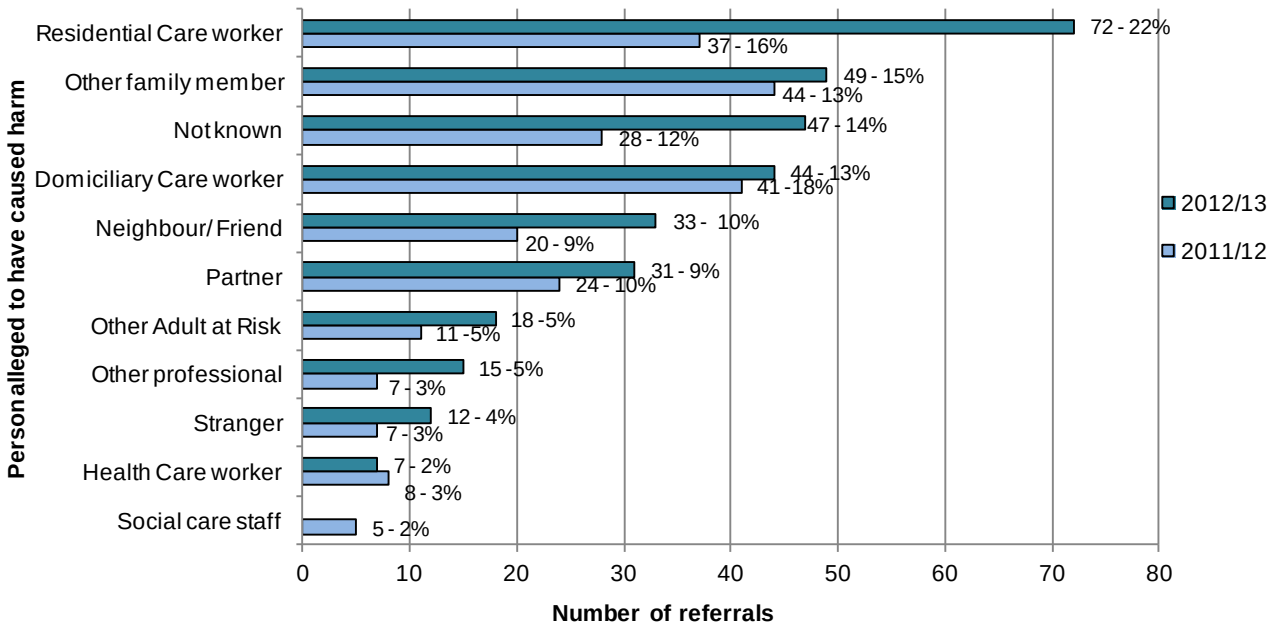
***Comment**: this is consistent with the findings of national prevalence studies [11]/[12].*

[11] UK Study of Abuse and Neglect of Older People (National Centre for Social Research, 2007)

http://www.natcen.ac.uk/study/uk-study-of-abuse--neglect-of-older-people

[12] Adult Safeguarding Scrutiny Guide (Improvement & Development Agency, 2010) http://www.idea.gov.uk/idk/aio/19170842

Figure 7. Relationship of person alleged to have caused harm by year



8.8 Outcomes

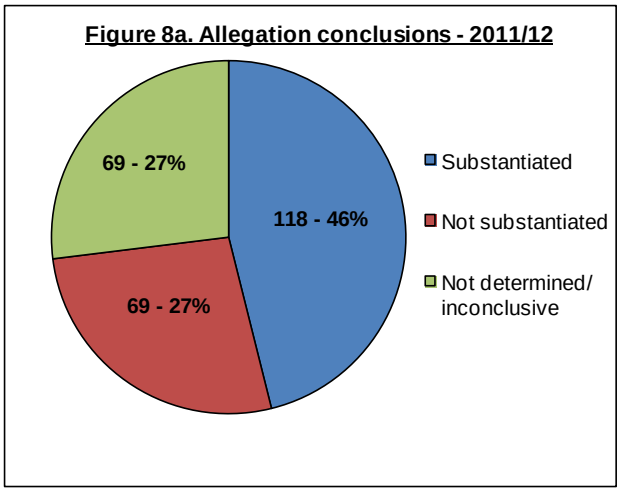
Case conclusions for individual allegations per referral are agreed at the safeguarding case conference meeting. It may not be possible to reach a conclusion on all allegations at that time.

In 2012-13 there were 244 concluded cases (including some for referrals received prior to April 2012) with 354 individual allegations. This was an increase from 2011-12 when there were 216 concluded cases with 256 allegations.

Comment: *This is a positive development and is a clear indication that safeguarding practice is increasingly robust in terms of screening alerts to determine whether or not they should progress through the safeguarding process.*

TABLE 4: Allegation conclusions by year

Allegation conclusion	2011/12		2012/13		% Difference
	Number	Percentage	Number	Percentage	
Substantiated/ partially substantiated	118	46%	134	39%	**-7%**
Not substantiated	69	27%	109	31%	**+4%**
Not determined/ inconclusive	69	27%	104	30%	**+3%**
Total concluded	256	100%	347	100%	-



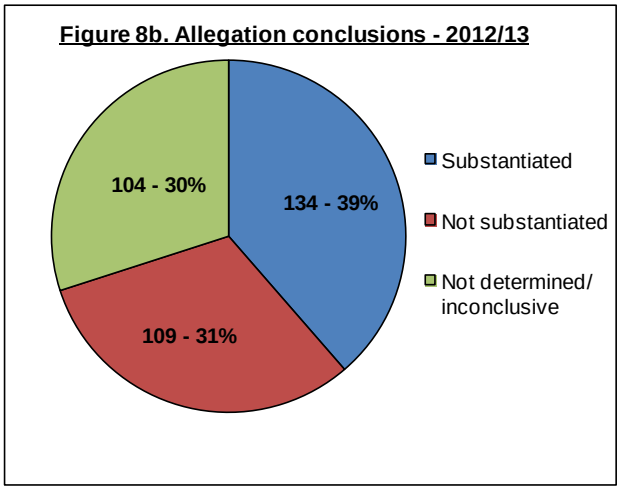


TABLE 5: Case conclusions by year

Allegation conclusion	2011/12		2012/13		% Difference
	Number	Percentage	Number	Percentage	
Substantiated/ partially substantiated	106	49%	110	45%	**-4%**
Not substantiated	42	19%	65	27%	**+8%**
Not determined /inconclusive	68	32%	67	28%	**-4%**
Total concluded	216	100%	242	100%	-

Figure 9a. Case conclusions - 2011/12

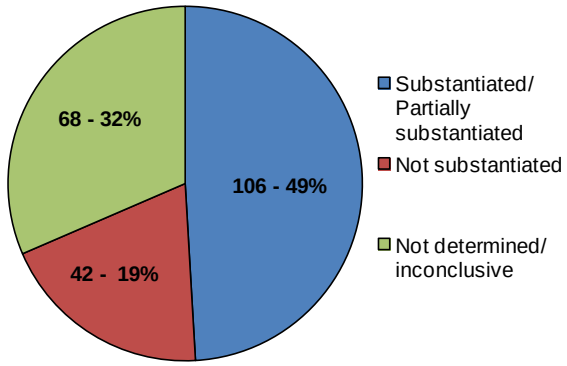
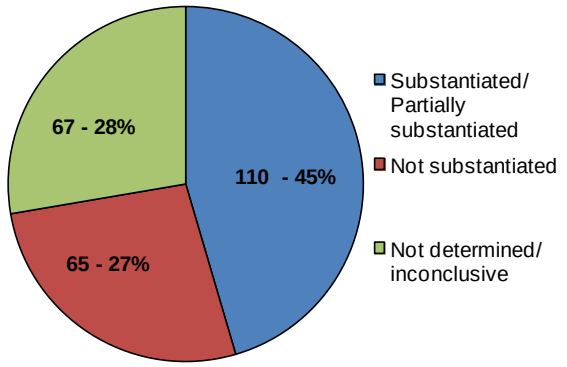


Figure 9b. Case conclusions - 2012/13



8.8.1 Case conclusions by service user group

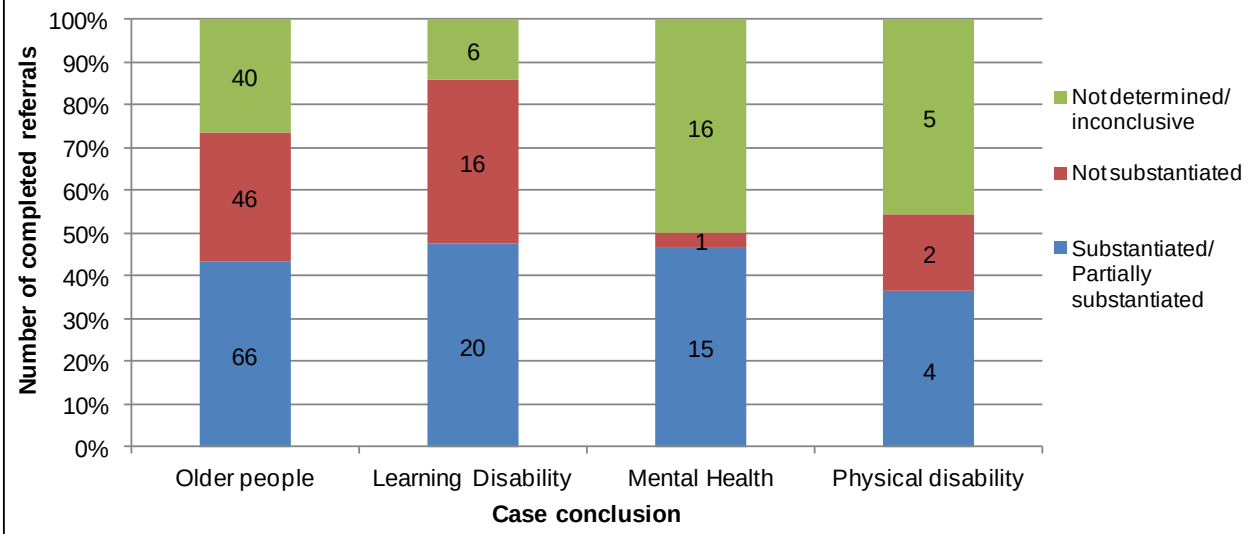
'Substantiated' case conclusions were more common for adults with learning disabilities and with mental health problems.

'Not substantiated' case conclusions were higher among learning disability cases.

'Not determined /inconclusive' case conclusions were most common for people with mental health problems whilst learning disability cases had a low percentage of 'not determined/inconclusive' conclusions.

***Comment**: what we mean by "Not Determined/Inconclusive". The NHS Information Centre's "Information and Guidance on the Abuse of Vulnerable Adults Collection (AVA)" formalised the categories of outcomes in safeguarding adult and defines "Not Determined/Inconclusive" as being applicable in "cases where it is not possible to record an outcome against any of the other categories. For example, where suspicions remain but there is no clear evidence to substantiate".*

Figure 10. Case conclusions by service user group - 2012/13



8.8.2 Summary of safeguarding cases by service user group

TABLE 6: Safeguarding cases by service user group – 2012-13

Service user group	Alerts	Referrals	% Alerts that progressed to referral	Substantiated cases[13]
Physical disability	47	15	32%	4
Older people	557	178	32%	66
Mental health	113	50	44%	15
Learning disability	113	75	66%	20

8.8.3 Outcome of concluded referral – adult at risk

The 244 cases concluded in 2012-13 resulted in 330 outcomes for the adults at risk. The breakdown below is based on outcomes and therefore percentages do not add up to 100% due to a high number of cases having more than one outcome for the adult at risk:

- 39% (94) of cases resulted in increased monitoring
- 37% (89) of cases resulted in no further action
- 12% (29) resulted in a community care assessment and services
- 12% (30) resulted in movement to increased or different care
- 7% (18) resulted in restriction/management of access to person alleged to have caused harm
- 6% (15) resulted in a review of self-directed support
- 5% (13) resulted in management of access to finances
- 5% (11) resulted in a referral to counselling/training
- 4% (10) resulted in the adult at risk being removed from property or service
- 3% (6) resulted in a referral to Multi-Agency Risk Assessment Conference (MARAC)

8.8.4 Substantiated case conclusions by person alleged to have caused harm

In 2012-13 there were 83 safeguarding cases that were concluded to be substantiated. In these cases the people alleged to have caused harm were as follows:

13 Some of these case conclusions may have been for referrals received prior to April 2012 and therefore do not relate to the referrals listed in this table.

- 44% were family, friends or neighbours (17% partners, 15% neighbours/friends and 12% other family members)
- 31% were care workers (13% in care homes, 12% home care, 5% health care & 1% personal assistant)
- 6% were another adult at risk
- 4% were strangers
- 1% were other professionals

8.8.5 Outcome of concluded referral – person alleged to have caused harm

The 244 concluded cases resulted in 305 outcomes for the people alleged to have caused harm. The breakdown below is based on outcomes and therefore percentages do not add up to 100% due to a high number of concluded cases having more than one outcome for the person alleged to have caused harm:

- 45% (109) of cases resulted in no further action
- 25% (61) resulted in continued monitoring
- 8% (20) resulted in police action
- 7% (18) resulted in counselling/training/ treatment
- 7% (16) resulted in disciplinary action
- 5% (11) resulted in management of access to the adult at risk
- 5% (11) of person alleged to have caused harm outcomes were 'unknown'
- 4% (10) resulted in community care assessment
- 4% (10) resulted in referral to POVA/ISA
- 3% (8) resulted in action by contract compliance
- 3% (7) were recorded as 'exoneration'
- 3% (6) resulted in removal from property or service
- 3% (6) resulted in action under the mental health act
- 3% (6) resulted in a criminal prosecution or caution
- 1% (3) resulted in referral to registration body
- 1% (2) resulted in referral to court mandated treatment
- >1% (1) resulted in action by CQC

8.9 Provider Performance

The following provides a summary of an analysis of safeguarding referrals (where in this context an alert proceeded to at least preliminary investigation) in 2012-13 where the allegation of abuse was related to the service delivered by a care home in the borough of Richmond or a home care provider used by the Council. Individual providers are not named for confidentiality reasons.

Homecare; During the 2012-13 financial year, there were 42 safeguarding referrals for 7 homecare agencies that provide care to approximately 480 people at any one time. Of these 44 referrals, 12 (29%) were substantiated for 5 of the 7 agencies; 11 for neglect, and 1 for financial abuse.

	2011/12	2012/13
Referrals	30	44
Substantiated cases	5 (17%)	12 (29%)

Older peoples care homes; There are 20 care homes in the borough providing care for about 860 beds. In 2012-13 there were 108 safeguarding referrals for 16 of the 20 homes. Of these 108 referrals, 37 (34%) were substantiated for 10 care homes, and the majority of these were for neglect (26) and physical abuse (13) while 17 were part of an institutional safeguarding investigation for one home.

	2011/12	2012/13
Referrals	88	108
Substantiated cases	25 (28%)	37 (34%)

Learning disability; there are 25 registered learning disability care homes in the borough, with about 170 beds. In 2012-13, there were 38 safeguarding referrals for 17 learning disability care homes in the borough. Of these 38 referrals, 18 (47%) were substantiated for 8 different providers and the reasons for these were physical abuse (4) neglect (7) and institutional abuse (8) for two different homes.

	2011/12	2012/13
Referrals	14	38
Substantiated cases	2 (14%)	18 (47%)

Quality Assurance

Richmond Council's Quality Assurance (QA) service conduct regular monitoring meetings and liaise with other professionals and health commissioners to monitor provider performance and support providers to deliver actions as a result of issues identified during safeguarding investigations. Where remedial actions are required of the provider, QA monitor progress to ensure service improvements are achieved.

As an example: where a safeguarding incident identifies requirement for further staff training, QA will follow up with the provider to ensure that this is put in place. They

also provide expertise and best practice guidance as part of safeguarding investigations. The ongoing quality assurance work with providers is monitored by senior managers in the council on a monthly basis. This oversight ensures that services improve and people are made safe.

The QA Service and the Council's Head of Safeguarding attend quarterly liaison meetings with the *Care Quality Commission* to share intelligence about local care provider services.

8.10 Timescales

A more robust system for monitoring timescales has been put in place in 2012-13, resulting in all safeguarding measures meeting their targets.

TA BLE 4: Wait between alert and safeguarding decision

	Q1	Q2	Q3	Q4	Full Year	Target
% of cases completed within timeframe	91.4%	93.8%	92.2%	92.2%	92.4%	90%

TABLE 5: Wait between alert and strategy meeting (5 working days)

	Q1	Q2	Q3	Q4	Full Year	Target
% of cases completed within timeframe	72.7%	56.5%	70.6%	91.2%	70.5%	70%

TABLE 6: % of case conferences co-ordinated within 5 wkg days of investigation

	Q1	Q2	Q3	Q4	Full Year	Target
% of cases completed within timeframe	67.6%	75.9%	77.8%	73.3%	72.8%	70%

TABLE 7: % of first reviews undertaken within 3 months of case conference

	Q1	Q2	Q3	Q4	Full Year	Target
% of cases completed within timeframe	90.5%	85.7%	90.5%	92.3%	86.3%	80%

TABLE 8: % of second reviews undertaken within 6 months of the first review

	Q1	Q2	Q3	Q4	Full Year	Target
% of cases completed within timeframe	100%	100%	100%	100%	100%	80%

8.11 User satisfaction

TABLE 9: Number of people who have a follow up contact to review their experience of the safeguarding process

	Full Year
Number of people	7

TABLE 10: Percentage of cases where the Adult at Risk and/or their representative provide service user feedback.

	Full Year
% of cases	100%

Comment: *a formal framework for capturing face-to-face feedback from Adults at Risk and, where appropriate, their representatives, was developed by the Safeguarding Adults Team and introduced within LBRuT Adult Community Services Teams in October 2012. The figures shown above therefore are for Quarter 4 of 2012 -13 only.*

*The **Individual Safeguarding Record** (ISR) is a three part tool that seeks to engage and inform Adults at Risk at the beginning of the safeguarding process (Part 1), throughout the process (Part 2) and evaluate their experience, and gain feedback about how we can improve, at the close of the process (Part 3).*

Feedback received from Adults at Risk to date has been generally positive about the safeguarding process though some have identified that they became confused by professional "jargon" and others felt the meetings could have been shorter. The Head of Safeguarding will address these issues directly with staff.

Going forward, The Information Centre and DOH are planning to launch a pilot study on "Safeguarding Outcomes" from a Service User perspective with a view to rolling this out nationally. In actuality the Information Centre's proposed tool closely resembles LBRuT's Part 3 which is a pleasing indication that we are already on the right track. LBRuT will take part in the pilot study.

8.12 Deprivation of Liberty Safeguards (DoLS)

Background Information

Managing Authority

Within the DoLS legislation a *Managing Authority* is either a Care Home or a Hospital. Managing Authorities must apply to the Local Authority where the Care Home or Hospital is situated for a deprivation of liberty authorisation if they believe a person in their care lacks capacity to decide on where they should be treated or cared for, and they can only provide care for that person in circumstances that may amount to a deprivation of their liberty.

Standard and Urgent Authorisations

A Managing Authority must request a *Standard Authorisation* from their Local Authority when it appears likely that, at some time during the next 28 days, someone will be accommodated in their institution (either a Hospital or Care Home) in circumstances that amount to a deprivation of liberty. This request should only be made *after* rigorous care planning indicates that less restrictive measures cannot meet the person's needs.

Managing Authorities can issue themselves with an *Urgent Authorisation* where there is an immediate need - in the best interest of the person in order to protect them from harm - to deprive someone of their liberty. Urgent Authorisations are valid for a maximum of 7 days. When making an Urgent Authorisation, Managing Authorities must simultaneously make a request for a Standard Authorisation to the Local Authority. The assessment process must be then completed before the 7 day period of authorisation expires.

Conditions

The *Best Interest Assessor* (BIA) assesses whether a person is actually deprived of their liberty and may recommend that specific conditions should be attached to a deprivation of liberty authorisation. For example, they may make recommendations around contact issues or the appropriateness of the current placement, or other such issues related to the deprivation. If the conditions stated in the assessment are not dealt with it might mean that the deprivation would cease to be in the person's best interest. The BIA may also recommend conditions to work towards avoiding the deprivation of liberty in the future. Conditions should not be set to deal with general care planning issues.

8.13 Performance

During Quarter 4 [14] of 2012 -13 there were a total of 6 new requests for Deprivation of Liberty Safeguards (DoLS) authorisations all of which were made by the local authority.

Five out of the six requests received were Urgent Authorisations all of which were assessed within the 7 day timeframe. Of these five, only one Standard Authorisation was granted with the remaining four being declined due to the best interest requirement not being met and one individual being assessed as having mental capacity therefore rendering DoLS invalid.

There was one review instigated by the Managing Authority for the local authority during this quarter.

TABLE 11: No. of authorisation requests received this year that were completed

	Q1	Q2	Q3	Q4
Local Authority	2	8	5	6
NHS Richmond	1	5	2	0
TOTAL	3	13	7	6

[14] For purposes of this report statistics pertaining to DoLS were collated for the first time in Quarter 4 of 2012-13. DoLS statistics have always been submitted to the DOH and this will continue.

8.13.1 Current Authorisations

At the end of 2012-13 there were 5 people subject to a Standard Authorisation (4 from the local authority and 1 under Richmond Clinical Commissioning Group). The key themes that have been deemed to amount to a deprivation of liberty are as follows:

- Relevant person is purposefully objecting to being in the home/hospital on a daily basis.
- Supervised contact with family.
- Restricted access to family.
- Constant supervision.
- Unable to leave the home without supervision due to fear of relevant person's absconding, risk of wandering and risk of accidental injury.

The conditions set for authorisations are as follows:

- Extra staff input to facilitate the relevant person's involvement in different activities.
- Professionals meeting to explore alternative accommodation options

8.14 Supporting Information

The maximum authorisation period remains at 6 months as previously agreed by the LBRuT Supervisory Body. However, feedback from Best Interest Assessors indicates that some individuals subject to a DoLS actually find 6 monthly assessments distressing and struggle to cope with the rigors of these assessments. Going forward therefore the Supervisory Body will be asked to consider the possibility of extending this period to 12 months in circumstances where it seems unlikely the situation for the individual is going to change and where it is known that the person becomes distressed.

It has been agreed by the Supervisory Body that the two assessments completed by the Section 12 Doctor - the Eligibility and Mental Health assessment - can be used as "equivalent assessments" and will not therefore necessarily need to be repeated providing they have been completed within 6 months. There have had a number of short authorisations granted, for example, on the basis that alternative accommodation be explored but this matter has not been resolved within the identified timeframe. In accordance with the guidance in the DoLS Code of Practice is has been agreed that, in such circumstances – and providing DoLS still applies - the use of equivalent assessments completed by the section 12 within a 6 month period is appropriate as the situation would not have drastically changed.

The Council solicitor has started work with Best Interest Assessors (BIAs) to provide extra support and guidance from a legal perspective on their assessments. This will ensure that assessments are as robust as possible and can stand up to legal

scrutiny should the case be heard in the Court of Protection (CoP). It has also arranged for BIAs to attend the CoP to experience first hand how cases are processed. Initial feedback from one BIA who has attended highlights it was a very useful and enlightening experience.

The refreshed DoLS Policy and Procedure along with the Protocol for recruiting and managing BIAs has now been circulated.

09. REVIEW OF ACHIEVEMENTS 2012-13

This section reviews the progress of the Board and its constituent members.

A. Safeguarding Board Adults Partnership Board

In terms of outcomes for adults at risks and keeping people safe during 2012-13 the Board has:

- Received the overview reports from the independent chairs of the two respective Serious Case Reviews (SCRs). By their very nature Serious Case Reviews involve a thorough review of partnership working at operational level and the learning points identified as a consequence of the 2 Serious Case Reviews commissioned by the Board have resulted in a number of recommendations to improve safeguarding practice. The action plan for implementing the lessons learnt from the Serious Case Reviews is designed to improve practice within all partner agencies and thereby enhance our ability to keep people safe and to improve outcomes for all Service Users.

- Ensured that the model of robust safeguarding practice embodied by the Pan London Policy and Procedures is steadfastly implemented through the work of the Board, partners and its sub-groups: working in partnership with the adult at risk - to agree their protection plan, to improve their safety and to achieve positive outcomes - is of primary importance.

- Taken on board the lessons identified by Serious Case Review following Winterbourne View and subsequent updates relating to reviewing and monitoring residential settings in order to ensure that service users remain safe.

- Considered a process of appeal for adults at risk and their representatives where it is alleged that the safeguarding process was not rigorously followed and as a consequence did not achieve appropriate outcomes.

- Identified its key priorities going forward, based on the outcomes of the self assessment, which will feed into the Board's Business Plan, which focus on continuing to encourage Service User engagement and involvement at all levels.

In terms of governance arrangements during 2012-13 the Board has:

- Strengthened its membership: a representatives of the London Probation Service and the Housing and Richmond Housing Partnership joined the Board; the Board has also paved the way for the smooth transition of representation of the Clinical Commissioning Group (CCG) in the wake of the primary Care Trusts (PCTs).

- Continued to build upon the reciprocal chairing arrangements with Wandsworth and thereby further enhance the Board's objectivity.

- Strengthened its governance arrangements – including a refreshed terms of reference - following a self assessment exercise.

B. Learning & Development Sub-Group

The key achievements of the Group are:

Outcomes

The following Safeguarding courses were delivered during 2012-13 with a total of 213 people receiving training.

1. Bite-size IMCA training session
2. DOLS Applying Theory into Practice
3. DOLS Introduction - half day
4. Domestic Abuse - the MARAC Process
5. Introduction to the Mental Capacity Act
6. Mental Capacity Act and Good Practice
7. Safeguarding Adults Managers - 2 day
8. Safeguarding Adults-Roles and Response
9. Safeguarding Awareness (level 1)
10. SGA Investigators Role (2 days)
11. SGA Legislation and Policy
12. SGA Minute Taking for Administrators
13. SGA: Best Evidence & Interviewing Skills

Take up of training by sector was:

It should be noted that not all of the courses were a requirement for all sectors; people only attended the courses that they needed to for their level.

Sector/Service	Total number of courses attended
Commissioning Care Services	**124**
Community Services Operations	**31**
Corporate Policy and Strategy	**1**
Housing	**1**
Providers	**5**
CSC Specialist Services	**2**
Carers	**4**
Other	**20**
Other Borough	**31**
Police	**2**
PVI Homecare	**6**
PVI other	**1**
PVI res/Nursing	**37**
Health	**7**
Schools	**3**
SWL&StGMHT	**20**
Voluntary Sect	**17**
Grand total	**312**

Attendance on some of the courses was lower than anticipated. In response to this in 2013 -14 we are working more closely with members of the Board and Managers to ensure that all staff and volunteers are aware of the learning and development opportunities available.

A train the trainer programme will be introduced in 2013-14 which will enable care providers to train their own staff in their own establishments; this will have the additional benefit of working around staff shift patterns.

Implications for Practice

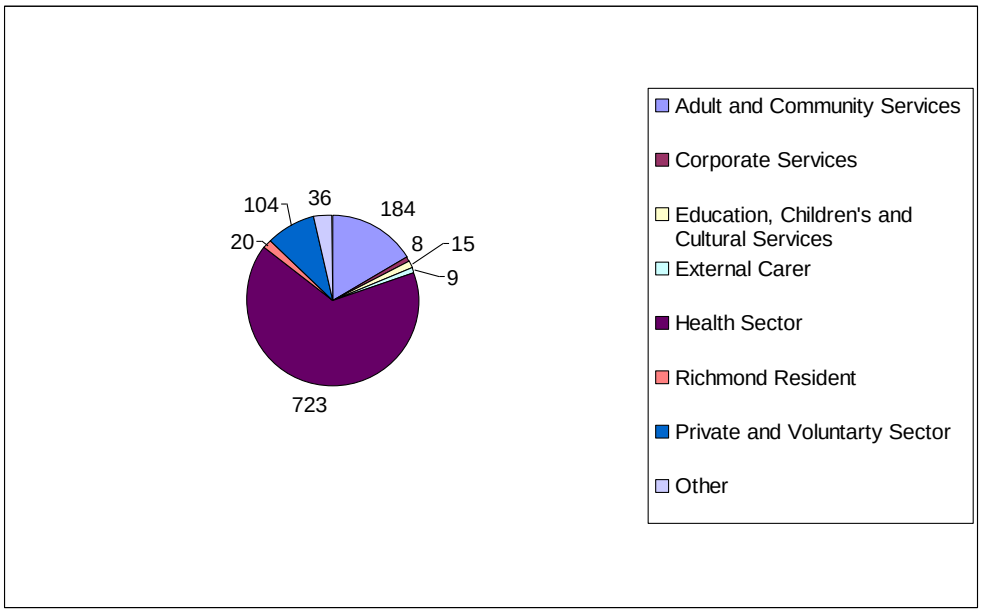
In addition to the training carried out described above further opportunities to improve safeguarding practice have been promoted through:

- The launch of the Safeguarding adults training Strategy
- A comprehensive review of the Safeguarding training to make more explicit links to the Safeguarding Adults competency framework
- A review of E Learning strategy and E learning programmes, have now made courses more accessible, courses updated, and utilising a wider variety of resources, such as SCIE, Skills for Care and use of video links.
- The introduction of a level 1 classroom based training, for those that can't access the E Learning, or who need to embed the level 1 E learning
- 6 Social workers have registered for the Safeguarding PQ at Kingston University this year, and 4 Social workers for the BIA at Bournemouth University
- Training on "Critical Reflection" has been commissioned; critical reflection is a core element of professional practice and has been highlighted throughout the new Professional Capability Framework (PCF) as a key skill to develop and maintain. Critical reflection workshops are being commissioned which will draw on Professor Jan Fook's well evaluated model of reflection to enable staff to explore and evidence their decision making skills. This will include decisions in relation to safeguarding practice.

Governance arrangements

The terms of reference and the membership of the Learning and Development sub group have been reviewed.

Number of Users accessing Safeguarding E Learning Courses 2012-13



Governance arrangements: the terms of reference and the membership of the Learning and Development sub group have been reviewed.

C Policy & Performance Sub-Group

The achievements of this Group are summarised as:

- Improved attendance from the statutory agencies with good attendance continuing from the voluntary sector which has increased confidence in the larger voluntary sector agencies in terms of the safeguarding policies and procedures and robust quality assurance systems they have in place.

- Performance data produced quarterly by the Council, both in relation to safeguarding activity and the performance of care homes in the borough and homecare agencies used by the Council. This has given the Board a good understanding of where there are safeguarding incidents with providers in the borough, the reasons why the safeguarding incident occurred and the action being taken by the borough in supporting providers. The Board also has strong oversight of the increase in safeguarding and how the Council Adult Community Service Teams are supporting the safeguarding process.

- Benchmarking of data comparing Council performance against other London boroughs in order to better understand where performance needs to be improved. The benchmarking of our data has shown that Richmond business processes generally perform well, with a high proportion of alerts progressing to referral indicating that referrals received were appropriate. It also shows that Richmond has a high proportion of safeguarding referrals in the care homes in the borough and this supports the targeted work that the Council is doing with the Clinical Governance group in rolling out a range of initiatives to improve the quality of care in care homes.

- Individual meetings arranged with statutory providers to understand how data can be gathered, provided and shared and will be taken forward into the 2013-14 work programme for the group. Whilst these meetings are still ongoing key messages from initial meetings show that communication between the council and partners needs to improve both during safeguarding investigations and in terms of raising the profile of the councils Quality Assurance Team so that partners are aware of who to contact when they have concerns about a provider.

- In terms of improving information to the public a new safeguarding leaflet and card, produced by the Safeguarding Adults Team, was distributed to all partners with the group identifying places for distribution.

- In conjunction with Richmond LINk the Council also produced an Adult Social Care Charter which was aligned to dignity in care standards http://www.richmond.gov.uk/adult_social_care_charter.pdf. The majority of members of the sub group produce similar standards for their service users and for those that don't these standards have also been provided as a guide for partners to follow.

D Serious Case Review Sub-Group

The work of the Serious Case Review Sub-Group is summarised in 7 above (pages 15-19)

E Individual Partners

Voluntary Sector:

As a member of the Board, Richmond CVS has been a consistent attendee of meetings and has supported activities to strengthen the Board's governance, for example, taking part in the audit. Richmond CVS has also devoted time to additional activities such as being an independent member of a Serious Case Review which took place during the year.

Richmond CVS has disseminated information and updates on Safeguarding to the VCS through e-bulletins to ensure that voluntary and community organisations follow good practice at all times. In particular the ROSE online training tool on Safeguarding Awareness has been promoted. Richmond CVS has also communicated comments and concerns from the VCS regarding the training tool to inform further work and development. RCVS will continue to be an active member of the Board in the coming year to support and promote the VCS role in Safeguarding.

Examples of how Safeguarding is being embedded in VCS working.

Richmond Carers Centre (RCC) lead the on the Carers Hub which provides a wide range of support to carers. RCC, together with their other VCS partners, have worked on raising the safeguarding agenda in a number of ways:

1. Safeguarding is a standing item on the Action for Carers Network meetings

2. RCC has promoted local training opportunities to other organisations regarding safeguarding for both children and adults

3. Staff and volunteers at RCC, at the very least take part in safeguarding training on ROSE on line training site. This is mandatory for all new staff and volunteers.

4. RCC has supported unpaid Carers who have safeguarding concerns through our support service.

5. RCC report to the Local Authority through Carers hub service monitoring statistical information regarding the number of safeguarding alerts. This is quarterly.

Other VCS partners in the Carers Hub, such as Integrated Neurological Services, have also supported carers and clients.

For example:

- 2 senior staff recently supported a resident in a Richmond care home potential safeguarding concerns were raised; a Professionals meeting was called as a consequence and the issues were discussed.

- 2 other staff have attended safeguarding meetings relating to a Richmond resident where concerns had been raised regarding his carer/wife.

LBRuT: Safeguarding & Community Teams

This year the Safeguarding & Community Teams have:

- Firmly established care governance arrangements within the Council's Adult Services, including the introduction of Safeguarding Surgeries and one to one specialist support for all staff where appropriate. The Safeguarding Team maintains an overview of all operational work as well as ensuring Council commissioning is allied to safeguarding.

- Introduced Performance Information as a standing agenda item at the Safeguarding Adults Performance Managers' Group, with attendance by the Performance Information Manager, in order to facilitate reciprocal understanding on the part of Team Managers and the Performance Team and thereby improve their ability to monitor and improve performance.

- Developed an audit tool and identified the parameters for reviewing the quality of safeguarding performance within Adult Care Services at operational level.

- Implemented a mechanism for involving Service Users and gaining their feedback – and the view of carers – to inform service improvement.

- Maintained a profile within the London Safeguarding Adults Network (LSAN) as well as the London wide Mental Capacity Act / Deprivation of Liberty Safeguards (DoLS) Network.

- Established robust working links with neighbouring Boroughs in South West London in relation to both Safeguarding and DoLS work.

- Built on established links with the Quality Assurance Team to ensure that routine care and contract monitoring is linked to adult safeguarding through regular meetings and regular attendance at Provider Forums.

- Established clear links within the Community Safety Partnership, including regular reporting to the Community Safety Group and regular attendance at MARAC and MAPPA meetings.

- Strengthened partnership working with Richmond Clinical Commissioning Group, South West London & St George's Mental Health Trust, Kingston Hospital NHS Foundation Trust and the Police and, in conjunction with the Quality Assurance Team, the Care Quality Commission.

- Supported the Chief Nurse (Richmond CCG) in the appointment of a Lead Nurse for Safeguarding Adults.

- Reviewed and quality assured safeguarding training in conjunction with Work Force Development.

- Introduced a protocol for responding to and managing concerns relating to Institutional/Large Scale abuse.

- Refreshed safeguarding publicity and introduced a “business card” with important contact details together with a new leaflet. The safeguarding webpage has also been refreshed.

LBRuT: Community Safety Partnerships

During the past year the partnership has:

- Continued the trend of reducing repeat victimisation, with the MARAC repeat case rate falling from 36% from last year to 30% for 2012-13. This is an impressive fall in the context of an increased awareness of the MARAC and a corresponding increase in non-police referrals from 18% last year to 44% for 2012-13. Even though the borough has managed to reduce repeat MARAC cases this year continued reductions will be challenging to maintain alongside the objective of ensuring that all high risk cases on the borough are referred to the MARAC. Although slightly below last year’s figure the borough was 7th highest out of 28 London boroughs for its referral rate per 10,000 female population.

- Ensured an excellent Domestic Abuse Service was in place; the joint contract with Children’s Services for the Domestic Abuse Service began in January 2012 has been very successful, with a strong performance management framework. The Service has 92.8% satisfaction (number of desired outcomes reached) 41% reduction in physical risk and 87% who feel safer after accessing the service for 2012-13.

- Ensured greater awareness about the MARAC and the effects of domestic abuse on adults and children through MARAC and Domestic Abuse awareness training and through a high profile White Ribbon Event.

- Participated in the Home Office pilot for testing whether ASB/hate crime issues have been dealt with properly which tested the proposed legislation for Community Triggers. Continued close working with the tenant’s champion and ongoing improvements to the case management process.

- Implemented clear protocols for case management/ sharing of information/ ‘dip sampling’ for domestic abuse, ASB/hate crime and integrated offender management.

- Ensured that all Community Safety Priorities are part of the performance management framework and have benefit measures attached to them. Domestic abuse is listed above. Benefits around Anti Social Behaviour ASB are linked in with the Council’s annual survey.

- Refreshed the Information Sharing Protocol for the CSP and reviewed the Risk Register for the Partnership.

- Successfully secured funding for Domestic Abuse Service and ASB through MOPAC bids.

LBRuT: Housing and Richmond Housing Partnership

Over the past year Housing and Richmond Housing Partnership has:

- Provided a “housing options” and “housing advice” service for customers where a range of issues can be discussed, covering all tenure types. This gives customers greater choice. Community engagement teams and tenancy support officers also offer individual support.

- Continued to utilise the Vulnerable Clients as a source of communication between teams and disciplines and to review cases through the Tenants Champion to identify if there are any thematic concerns that can be resolved strategically.

- Worked on a customer contact efficiency programme to make it easier to take “one view” of the customer and provide better quality information.

- Joined the membership of the Board in the coming year.

- Arranged joint shadowing and shared team meetings with Adult Care in order to maximise learning and shared experience.

- Continued to roll out training around safeguarding issues for new starters.

- Sustained standards through efficient working and through minimum meetings with maximum output.

The Police

The Detective Inspector of the Community Safety Unit has been working closely with the Head of Safeguarding to develop a new communication protocol to streamline the inter agency ‘Adults at Risk’ referral pathway. They key developments are:

- The Public Protection Desk (PPD) will now act as the Single Point of Contact for Adult and Community Services (ACS)

- The PPD Detective Sergeant (DS) will be responsible for engaging in the initial strategy discussion with an ACS manager.

- The PPD DS will advise ACS as to whether a criminal allegation needs to be formally recorded and investigated by the Police.

- The PPD will create the crime (CRIS) report upon receipt of a detailed Safeguarding Alert form from ACS & will record on the CRIS the result of the strategy discussion.

- The PPD will forward the report for further investigation to the relevant Investigative Unit (e.g. the Community Safety Unit (CSU) in most cases; CID or Neighbourhood Policing Team (NPT) depending on the circumstances.

This process anticipates the planned role PPD staff will have in due course within the MASH (Multi-Agency Safeguarding Hub) & provides a clarity & structure to communication that will enhance the multi-agency response to Adults Safeguarding.

Following significant organisational changes to the Police as a result of the implementation of the Local Policing Model, the appropriate level of representation & commitment to active participation at Board meetings has been agreed.

The Police are fully committed to working closely with partner agencies to take positive action to address the risks posed to vulnerable adults at risk.

NHS ORGANISATIONS WITHIN THE BOROUGH

Richmond Clinical Commissioning Group

Richmond Clinical Commissioning Group (CCG) takes seriously the responsibility of ensuring adults at risk, who use the services the CCG commissions, are safe from harm, and that the members of staff in those organisations are up to date in recognising and reporting safeguarding concerns.

Over the past 12 months there have been major changes in the local health economy and Richmond CCG has now superseded the old Primary Care Trust.

During this time the CCG has:

- Appointed a new Chief Nurse, who came into post in May 2013; part of the chief nurse role is to be the Executive Lead for safeguarding adults across the CCG.

- Appointed a new Lead Nurse for Safeguarding Adults; the Lead Nurse role is for 22.5 hours per week and is the main person responsible for safeguarding adults across the CCG.

- Reviewed all people with a learning disability, with funding provided by the CCG, who have been placed out of borough. Those people in special hospitals in assessment and treatment centres were reviewed and action

plans put in place to bring them back to the London Borough of Richmond upon Thames or as close to home as possible. There is ongoing joint working between the Local Authority and Richmond CCG to find suitable accommodation that will meet the specialist needs of these people. These actions follow on from the Winterbourne View Serious Case Review.

- The Learning Disability Self Assessment Framework, which monitors and sets targets for improvements in the area of health for people with a learning disability, is showing improvements in most of the specified areas. Work is ongoing to implement the recommendations from the Winterbourne View Serious Case Review but good progress has been made.

- A new health and social care reviewing officer post has been agreed with joint health and social care funding. The purpose of this post is to specifically review and monitor all people with a learning disability who are placed out of borough in all types of care services and who are funded by continuing healthcare.

Hounslow and Richmond Community Healthcare Trust (HRCH)

In the past year HRCH has:

- Completed a second NHS London Safeguarding Adults Assessment Framework in 2012. This year the self-assessment was validated by the North West London Cluster and the South West London Cluster. The assessment process allowed the organisation to review progress from the initial self-assessment and identify areas that need further development over the coming year. These areas for development have been incorporated into the Trust's Safeguarding at Risk Work Programme as have comments made by the Clusters.

- Participated in the Safeguarding Adults Partnership Board self assessment; feedback relating to the overall performance of the Board and the individual feedback received by the Trust will be used more broadly and has been fed into the HRCH Adults at Risk work programme.

- HRCH's safeguarding committee recommended to the HRCH Trust Board that a dedicated adult at risk post be developed to ensure that HRCH's commitment to providing high quality services to our most vulnerable clients is achieved. As a result funding was identified for a dedicated Adult at Risk nurse post. This post is currently out to advertisement and will facilitate HRCH's greater participation in the Adult Safeguarding Sub-Groups for both

Richmond Borough and Hounslow Borough as well as ensuring there is

specific resource to implement all aspects of the work programme.

- The Trust Board also agreed to enhance the overall safeguarding team with the development of a Head of Safeguarding role. This will provide strategic leadership and ensure that HRCH's commitment to ensure adults and children at risk is held at the same level and priority by the Board.

- The HRCH Trust Board set a target of 95% of staff to be trained in safeguarding adults at risk. In April 2012 the uptake of adults at risk training was 34%. Following a concerted campaign HRCH has improved the uptake of this training which at the end of March 2013 was 91%. Although this is a significant improvement as the target level set by HRCH Board is 95%, work will continue to ensure this target is met.

- Concentrated on ensuring that staff attended safeguarding adults at risk training. Therefore this area of work has been identified for progression in 2013/14.

- Internal safeguarding adults at risk procedures were put in place which identify how staff can access senior support and supervision in relation to safeguarding cases.

- Supervision of staff involved in safeguarding alerts, investigations or meetings has been recognised within the new HRCH clinical supervision policy which is currently under review.

- Work on the Safeguarding Adults at Risk work plan was discussed and reviewed at the HRCH Public and Patient Involvement Committee. In Hounslow users and carers are invited to attend Adults at Risk Strategy meetings, alongside Borough staff, HRCH staff and staff from other agencies. Their views on the meetings are sought. Feedback from meeting is intended to feed into all HRCH adults at risk processes.

- Metrics were not developed in this year (as identified in last year's annual report) therefore this area of work has been identified for progression in 2013/14.

South West London & St George's Mental Health Trust

This year the Trust has:

- Appointed an e-learning lead to develop new e-learning packages to increase the accessibility of key clinical knowledge bases and made the decision to design an e-learning package using Department of Health guidance, Pan London Policy (SCIE) and National Competences (Bournemouth) as the knowledge base and make use of the in-house expertise to adapt to the service specific issues within the Trust.

- The e-learning safeguarding package is now mandatory for all staff (clinical and non-clinical) and is supplemented by half day practice based sessions for those in a role requiring higher levels of competence.

- A new safeguarding adults' software package has been added to the existing Safeguard system used to record Serious Incidents, Complaints, Litigation, and PALs etc.

- The mental health teams, with considerable support from LBRuT, are currently focussing on ensuring Frameworki is updated (this is in addition to the Trust information system which all clinicians record on). It is anticipated that Trust usage of Frameworki will improve with the installation of the N3 connection which means staff can use Trust computers to access Frameworki.

- The Trust has been working to embed ownership of responsive safeguarding practice in day to day good practice, and to improve local and corporate governance, operational management oversight, outcomes and service user (and carer) experience. The key to this has been clarifying and distinguishing operational and governance responsibilities and accountabilities at all levels in the organisation.

- Adult safeguarding is now becoming every day business for all members of staff and all teams. Within direct services, opportunities are being developed to facilitate oversight of safeguarding practice by operational managers. Governance structures and reporting accountability have been developed together with systems to facilitate oversight of performance and quality information at Borough, Directorate, and Corporate level. In the London Borough of Richmond, at the instigation of LBRuT's Safeguarding Adults Team, we have established a Safeguarding Adults Improvement Board which is chaired by the Safeguarding Adults Lead for the Richmond Clinical Commissioning Group.

- The development of a centralised data system to enable the two Quality Accounts to be measured has been a major achievement of lasting benefit.

The centralised data system enables safer Trust wide governance of safeguarding adult cases, enabling tracking, quality assurance and audit. All Trust directorates are now either using this system, or are within a planned transition period to commence use. It is currently implemented in five of the six Borough or Directorate areas The Trust can evidence its ownership of adult safeguarding, and can now go on to use it to ensure timely and proportionate responses to safeguarding concerns, as well as reporting on the quality of the safeguarding adult service it provides.

- Reports are generated on weekly and monthly basis to provide senior management oversight as well as Trust Board reports, and other internal and external reporting requirements. It also generates KPI reports on the Quality Account measures. The centralised data system is a key element of the new governance structure for all safeguarding adult activities.

- The Trust measures the allocation of a Safeguarding Adults Manager within five days and recognises this as a useful measure of promptness and management grip of safeguarding matters. The Trust has been able to provide assurance that all cases meeting the relevant threshold were subject to an appropriate level of professional scrutiny at the crucial early stage of the process.

- The Trust's internal target of offering 80% of service users whose cases went to case conference the opportunity to feedback on their experience of safeguarding adults process, was met. The centralised data system was one of the methods by which all relevant cases were tracked throughout the year.

'Your Healthcare'

Your Healthcare CIC is a Social Enterprise commissioned by NHS Richmond (Richmond Clinical Commissioning Group (CCG) from April 2013), to provide specialist healthcare services for adults with learning disabilities in the London Borough of Richmond.

During 2012-13 Your Healthcare has:-

- Contributed to complex investigations undertaken under the Safeguarding Adults procedures.

- Attended the monthly Kingston Hospital Safeguarding/Learning Disability Steering Group.

- Provided performance data to NHS Richmond regarding the number of adult safeguarding alerts received and/or raised by Your Healthcare staff, the

number of safeguarding meetings attended and the number of complex investigations with health involvement.

- Established a Safeguarding Committee which reports to Your Healthcare's Board.

- Raised the profile of safeguarding adults in Your Healthcare by providing a report to Your Healthcare's Board on a bi-monthly basis as a standing agenda item. Safeguarding adults has also remained a standing item on the LD governance meeting agenda.

- Ensured that mandatory safeguarding adults training is available for all staff including Directors and Non-Executive directors.

- Completed a review of the whistle blowing policy.

- Implemented the action plan generated as a result of the self assessment.

- Continued to ensure that safeguarding issues are discussed at weekly LD team meetings.

Kingston Hospital NHS Foundation Trust

Last Year's Activities were:

- The Director of Nursing as Trust Lead for Safeguarding is responsible for reporting to the Board on matters relating to leadership across the organisation, strategic safeguarding objectives and outcomes, and ensuring partnership working with other agencies.

- The Care Quality Commission carried out a visit in October 2012, checked the Trusts records, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use the Trust's services. The inspection found that the Trust was compliant with Outcome 7, "safeguarding people who use services from abuse".

- The inspection found clear evidence to demonstrate that safeguarding arrangements are sufficiently robust to minimise the risk of people using the services being abused, harmed and/ or neglected. The CQC noted the Trust had acted upon the outcomes from safeguarding investigations and reviews to identify risks and implement areas for improvement.

- Kingston Hospital NHS Foundation Trust submitted its SAAF returns to local safeguarding adult's boards for oversight and challenge. Submissions were

then sent to cluster Director of Nursing's for validation. Each cluster held a validation meeting with NHS London to demonstrate understanding of the safeguarding capacity and capability of all NHS Commissioning and Provider organisations within the cluster. All areas of the assessment for the Trust were reported as either effective or excellent.

- Four key staff have been trained to deliver PREVENT training across the Trust and is now part of mandatory training in the Trust. The Trust Board will receive their training in this area in July 2013. This will then be followed by a cascade through senior manager and Divisions over the remainder of the year.

- Throughout 2012/13 on-going work has continued to further reduce the number of patients developing pressure ulceration. Root cause analysis investigations following the development of Trust acquired pressure ulcers allowed us to identify areas where further work was required within the Trust. A focus on the early assessment of patients at risk or with pressure ulcers was undertaken with specific emphasis on training in A&E and Acute Assessment Unit (AAU). Training included both pressure area awareness training and safeguarding training. Despite there being a 41% decrease in the number of patients developing Trust acquired pressure ulcers in 2012/ 13, work continues to take place to support the 'harm free' care strategy.

- Over the course of the year a group of staff have been working on a range of activities to improve assessment and treatment of patients with dementia. A series of study days and awareness sessions have been provided along with numerous audits, including patient experience feedback. Staff are increasingly recognising and responding to delirium and we are working on improving our communication strategies to assist patients who have symptoms of delirium and/or dementia. The group have done a lot of preparatory work over the year and in April 2013 we launched our Dementia Champions initiative to help raise awareness of the needs of our patients with dementia. To support this we have launched the "Forget me Not" scheme, which helps to easily identify our patients with dementia by placing a flower symbol on both patient summary boards and above patients' beds. We have given identity badges to staff who sign up to our pledges for dementia patients – our Champions. In the coming year a revised strategic plan for patients with dementia is being developed and implemented.

- Trust policies and procedures are up to date

- Kingston SAPB agreements in place and up to date (host Borough)

Kingston and Richmond probation, London Probation Trust

The Board member for Kingston & Richmond probation took over the senior management lead responsibilities for London Probation Trust, in respect of Safeguarding Adults in September 2012 and joined the Board in early 2013. During that time the following has been achieved:

- A pan-London practitioners forum has been established which meets quarterly. The group consists of staff from different teams across London Probation. The meetings discuss areas of significance and best practice.
- A bi-monthly Safeguarding Adults Strategic group has been established which is attended by relevant senior managers and subject leads. This group provides the strategic oversight for the Safeguarding Adults work across London Probation Trust.
- A Safeguarding Adults page has been established on the London Probation Trust intranet. This includes useful information and resources for staff and service users.

10. PRIORITIES 2013/14

As a consequence of the Board's self assessment in December 2012, the following *key targets* were agreed for 2013-14. These targets are in line with the strategic priorities identified within the Foreword to the report.

Key Target 1 – Continuing to raise awareness

Continue to raise awareness of safeguarding adults amongst:

- Professional staff: by maintaining a robust training and development programme in safeguarding for staff across all sectors ensuring that all staff have the ability to identify and respond appropriately to abuse and neglect of an adult at risk;
- Service Users: by ensuring that all Service Users are supported in raising an alert if they are being abused or neglected;
- The public: supporting the prevention of abuse by raising the profile of safeguarding through pertinent publicity material.

Key Target 2 – Continuing to encourage Service User involvement

Continue to develop and implement a range of strategies to encourage Service User involvement in the activities undertaken by the Board and across the Partnership, in order to improve Service User outcomes and ensure that the wishes of the Service User are taken into account at all times.

Key Target 3 – Ensuring that robust policies and procedures are in place

Ensure that policies and procedures are in place that facilitate robust monitoring of safeguarding practice between partner agencies and maintain communication channels and knowledge sharing in order to perpetuate continued learning and improvement, target resources effectively and improve safeguarding outcomes.

Key Target 4 – Strengthening the structures supporting the Board

Continue to build on existing structures already established for the effective governance of the Board, ensuring that clear arrangements are in place to promote safeguarding facilitating transparent accountability of both the Board and its partners.

Learning & Development Sub-Group

The Group will continue to act on behalf of the SAPB and will:

- Continuing to embed the Safeguarding Adults training strategy, by ensuring that all training reflects the Safeguarding Adults Competency framework (Key Target 2)
- Working alongside the partner agencies in exploring ways to promote awareness of Safeguarding Adults.(Key Target 2)

Policy & Performance Sub-Group

The Group will continue to act on behalf of the SAPB to:

- Continue to hold individual meetings with statutory providers to understand how data can be gathered, provided and shared with the objective that by the end of the financial year the Board will receive data either directly from the partners or through relevant data from the council gathered during the safeguarding process (Key Target 3).

- As part of that process agree with each statutory partner how data is shared. (Key Target 1, 2, 3).

- Facilitate shared learning across care providers (Key Target 2).

- Work with the Safeguarding Adults Team to promote Service User Engagement (Key Target 4).

Serious Case Review Sub-Group

The Group will continue to act on behalf of the SAPB to monitor robust implementation of the action plans resulting from the two Serious Case Reviews. (Key Target 1, 2, 3)

Individual Partners

A. The Voluntary Sector

RCVS will:

- Work in the coming year to support the aims and objectives of the Board. (Key Target 1)

B. LBRuT: Safeguarding & Community Teams

The service will continue to focus on improving outcomes and will:

- Build on existing mechanisms for engaging Service Users and Carers as part of a rolling programme for achieving more robust engagement (Key Target 2).

- Continue to support the administration of the Board, including supporting the Sub-Groups of the Board as appropriate. (Key Target 1).

- Continue to support the SCR Sub-Group in implementing actions identified from the two Serious Case Reviews. (Key Target 1, 2, 3)

- Work with all partners to promote safeguarding including continuing to co-ordinate safeguarding investigations (Key Target 3).

- Continue to maintain an overview of safeguarding practice (Key Target 1).

- Continue to lead the way for effective Service User consultation, engagement and empowerment within the safeguarding process as determined by PLP. (Key Target 2).

- Continue to develop a rolling programme for Service User involvement in the activities undertaken by the Board and across the partnership in order to improve Service User “outcomes” and ensure that their wishes are taken into account at all times. (Key Target 2, 4).

- Work with LBRuT’s Work Force Development Team and the Board’s Learning and Development Sub-Group to quality assure safeguarding training and to commission further training where need is identified. (Key Target 2).

- Maintain and further develop safeguarding publicity (Key Target 2).

- Work with Richmond Clinical Commissioning Group to promote safeguarding training for GPs (Key Target 2).

LBRuT: Community Safety Partnership

During the coming year the Partnership will:

- Carry out sampling for ASB/hate crime cases to improve customer experience. Work closely with the village plans as well as with the tenant's champion. (Key Targets 1, 2, 3, 4)

- Continue to work with Troubled Families, Integrated Offender Management and substance misuse to improve data and case management. (Key Target 1, 3)

- The Domestic Abuse Service is to be re-commissioned in January 2014; this will have the addition of the MARAC Administrator role as part of the contract to improve effective working. (Key Target 1, 3)

- A Domestic Homicide Review protocol will be written and agreed. (Key Target 1, 2)

- Prioritise communications for low level high volume crime and protecting victims and around Domestic abuse and ASB/hate crime (Key Target 2)

- Utilise partnership working towards a joint approach to Partnership campaigns, including radio, newsletters, twitter, posters, website and training (Key Target 2).

- Continue to encourage customer feedback as part of the Partnership's improvement process (Key Target 2, 4)

- Sustain standards through increased partnership working to provide the same level of service. Community Safety remains a priority for the Council. (Key Target 1, 2, 3).

- The Community Safety Partnership Plan for 2014-17 will be written and agreed following the annual Strategic Intelligence Assessment. (Key Target 1, 3).

- Prioritise communications for low level high volume crime and protecting victims and around Domestic abuse and ASB/hate crime. (Key Target 1,3)

- Utilise partnership working towards a joint approach to Partnership campaigns, including radio, newsletters, twitter, posters, website and training. (Key Target 3)

LBRuT Housing and Richmond Housing Partnership

During the coming year LBRUT Housing and Richmond Housing Partnership will:

- In anticipation that housing people in the private sector will become more difficult to achieve locally we will ensure adult safeguarding issues are addressed if we house someone outside of Richmond.

- Look at the effects of welfare reform and whether the financial pressures on households has a safeguarding element

- Use the winter warmth campaigns as an opportunity to look at customer welfare.

The Police

The Police will work to support the aims and objectives of the Board in the coming year. (Key Target 1)

Richmond Clinical Commissioning Group

In the coming year Richmond CCG will:

- Continue with the joint working with the Safeguarding Adults Team and the Council to develop GP training on safeguarding for adults at risk. It is anticipated that this training will commence by September 2013. (Key Target 2)

- Ensure that all members of Richmond CCG Governing Body will receive safeguarding training in September 2013. (Key Target 2)

- Within the older peoples care area, funding has been agreed for the post of care home support nurse. Going forward this role will support local older peoples care providers with issues on specialist nursing care, adult safeguarding and infection control. This post will work with both the health and social care quality teams. (Key Target 2, 4)

- The CCG will continue to have representation and active participation in the Safeguarding Adults Partnership Board and pertinent sub groups. (Key Target 1)

- The CCG will continue to be a key participant in the monitoring and support of provider organisations to ensure they are up to date with safeguarding training and reporting. (Key Target 1, 2)

- From the 1st April 2013 any serious incidents that occur within health services where Richmond CCG is the lead commissioner will be overseen and reviewed by the CCG quality team and action plans are scrutinised and monitored. (Key Target 1, 3)

- In line with the serious incident guidelines all Grade 3 or above pressure ulcers should be considered for safeguarding adult alerts and a decision as to whether to refer to the Care Quality Commission. (Key Target 3)

Kingston Hospital NHS Foundation Trust

The Trust will:

- The Trust has a good record of attendance at Board meetings and will continue to field an appropriate level of representation at Board meetings. (Key Target 1)

- Engage with the safeguarding agenda and make an effective contribution to the work of the Board (Key Target 1)

- Present this Annual Report to the Kingston Hospital NHS Foundation Trust's Board and the public and thereafter publish the report on the Trust's website (Key Target 1& 2)

- Safeguarding Adult lead managers/ practitioner Single Points of Contacts (SPOCs) should be in place in all Local Delivery Units to raise awareness locally of the safeguarding adults' agenda. (Key Target 2)

- Maintain the effective training programme in place at the Trust (Key Target 2)

- The dedicated nurse specialist will support patients and others in raising concerns. (Key Target 4)

- Kingston Hospital Trust and Your Healthcare have procedures in place which deliver person centred care including:

    - Patient passports
    - Joint protocol and pathways for patients moving between services
    - Communication and shared care systems between services
    - Partnerships with patients and carers - e.g. expert by experience initiatives
    - Kingston Hospital Trust's annual audit programme includes quarterly audits of learning disability patients "user experience" which is used to inform and adapt care. (Key Target 3, 4)

HRCH

In the coming year HRCH will:

- Continue to progress the HRCH Adults at risk work plan, participating in self assessment audits to monitor and measure progress. (Key Targets 1,2,3,4)

- Appoint to a dedicated adults at risk post (Key targets 1,2,3,4)

- Continued joint working with partners to improve the uptake and delivery of specialist training including MCA and DOLS (Key Target 2)

- "Adults at risk" has already been proposed as an area of improvement in the 2013/14 quality account, therefore ensuring due rigor and scrutiny at Board level. (objectives1,2,3 and 4)

- Increase the uptake of patient and user involvement in adults at risk work. (objectives 2 and 4)

'Your Healthcare'

During 2013-14 Your Healthcare will:-

- Continue to build on the achievements of 2012-13 particularly in relation to governance arrangements. (Key Target 1, 3)

- Recruit a Professional Lead for Safeguarding Adults (to start August 2013). The post holder will further develop awareness of safeguarding adults, review training programmes and provide more robust training data. She will also review current organisational policies and procedures relating to safeguarding adults. The role will also focus on further developing relationships and communication with partner agencies and service users and their families. (Key Target 1, 2, 3, 4)

- Provide a supervision and support system for staff involved in safeguarding cases and/or investigations. (Key Target 3)

West London & St George's Mental Health Trust

In the coming year South West London & St George's Mental Health Trust will:

- Going forward, the centralised data system introduced by the Trust will provide operational and performance managers with the information needed to ensure compliance with safeguarding adults' policy and maintain standards of practice. It will also provide an opportunity for detailed thematic analysis as it shows key information on timescales, those involved, and where incident occurred etc. (Key Target 3)
- All Safeguarding Adult Managers (SAMs) and Alerting Managers (as defined by the Pan London Policy) will be trained on how to enter data on this new centralised system. Access is limited to those who have had relevant training, and it is the SAMs who hold responsibility for updating the data records. (Key Target 2)
- Reports are generated on weekly and monthly basis to provide senior management oversight as well as Trust Board reports, and other internal and external reporting requirements. It also generates KPI reports on the Quality Account measures. The centralised data system is a key element of the new governance structure for all safeguarding adult activities. (Key Target 3)
- The Trust is currently completing telephone and face to face interviews with people who wished to give feedback and the process of carrying out this investigation will inform both practice development and future feedback mechanisms. The report from the feedback exercise will be fully available in July. The qualitative learning will inform service developments and these will be outlined in the report. (Key Target 4)

Kingston and Richmond probation, London Probation Trust

During the course of the year, Probation will:

- Continue to attend and contribute to the Safeguarding Adults Partnership Board meetings. (Key Target 1)
- Develop a training programme for practitioners. Two train the trainer events will be run in the autumn 2013 with the expectation that those who attend these events will then run local Safeguarding Adult awareness events in their LDUs or areas of operation over the winter/ spring. The plan is that hundreds of staff across LPT will attend these events. (Key Target 2)

- Run a local Safeguarding Adults awareness event. This will be an opportunity for Adult Safeguarding staff from Richmond and Kingston to meet with Kingston and Richmond probation staff to share knowledge and practice.
- Across London Probation Trust a Safeguarding Adult Single Point of Contact structure has been set up. In every LDU or part of the business there should be a SPOC who will promote Safeguarding and raise awareness of it.
- A national offender database to record the work undertaken with service users is being rolled out. I have made representations that the data fields will better capture information related to Safeguarding Adults.
- London Probation Trust has introduced a new case audit tool called LEARN 2. There are specific questions which reference the work that has been undertaken or should have been undertaken related to Safeguarding Adults. This is in respect of identifying 'adults at risk' and referring concerns to local Adult Safeguarding teams. It is anticipated this will give a better indication of the quality of work related to adults 'at risk' across London Probation Trust.
- London Probation Trust has advised all Local Delivery Unit (LDU) Assistant Chief Officers (ACOs) that there must be a management lead for Safeguarding Adults within their LDUs. The ACO or a Senior Probation Officer should attend the Safeguarding Adult boards for their boroughs.
- Helping Service Users raise an alert if they are being abused will be incorporated into the Safeguarding Adult awareness training which will be run across London Probation Trust.
- London Probation Trust is planning to introduce a Learning Disability Screening tool to be completed at the first point of contact with service users. This is to better identify service users with a learning disability as part of the pre-sentence report stage for the courts. Service users who are identified as possibly having a learning disability will be referred for further assessment.

11. APPENDICES

Appendix 1: SAPB TERMS OF REFERENCE

1. BACKGROUND

Why do we need a LBRuT Safeguarding Adults Board?

1.1 The Department of Health document "No Secrets" (March 2000)[15] recommended the establishment of Adult Protection Committees to oversee multi-agency scrutiny of the protection of vulnerable adults from abuse.

1.2 Section 1.5.3.1 of Pan London Procedures[16] sets out the need for the Safeguarding Adults Partnership Board to give priority to the prevention of abuse and for collective partnerships to integrate safeguarding into their work.

1.3 National developments reaffirm that the statutory lead for Safeguarding remains with each local authority, with a government recommendation (subject to consultation and final agreement) that such Boards be placed on a statutory footing.

1.4 Adult(s) at risk is the terminology used to describe vulnerable adults within the Pan London Procedures and is the term used throughout this document

2. PRINCIPLES AND AIMS OF THE BOARD

The context in which the Board will work

2.1 It is recognised and accepted that all adults:

- Have the right to live their life free from violence, fear and abuse.
- Have the right to be protected from harm and exploitation.
- Have the right to independence, which involves a degree of risk.
- Have the right to be listened to, treated with respect and taken seriously.

2.2 The statutory agencies, their partners, carers and Adults at Risk within LBRuT have a duty to ensure that these principles are upheld and take action where these rights are infringed.

[15] No Secrets (March 2000) Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse' (March 2000)

[16] Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse

2.3 The Safeguarding Adults Partnership Board (The Board) recognises and adopts the approach to safeguarding specified within "No Secrets", the Mental Capacity Act and other related legislation and policy. In LBRuT, The Board will:

- Reaffirm their commitment to a policy of zero tolerance of abuse within each of their member organisations.
- Work with openness and candour.
- Uphold the duty placed on public agencies under Human Rights legislation to intervene proportionately to protect the rights of citizens.
- Enforce the principle that any adult at risk of abuse or neglect should be able to access public organisations for advice, support and appropriate protection and care interventions, which enable them to live without fear and in safety.
- Recognise that citizens have a right to make their own choices in relation to safety from abuse and neglect, except where the rights of others would be compromised. In accordance with the principles of the Mental Capacity Act, interventions will be based on the presumption of mental capacity unless it is determined that an adult does not have the ability to understand and make decisions about his or her own personal well being and safety.
- Uphold the right to privacy. Information about an adult who may be at risk of abuse and neglect will only be shared within the framework of the Safeguarding Adults Information Sharing Protocol.
- Enforce their public duty to protect the human rights of all citizens including those who are the subject of concern but who are not covered by the Safeguarding Adults Procedures. This duty falls on each of the Board's member organisations who will offer people advice and support, as appropriate to their organisations, and signpost to other services.

2.4 The Board is positively committed to opposing discrimination on the grounds of race, religion, gender, age, disability, marital status or sexual orientation.

2.5 The role of The Board is to work as a multi-agency group that has:

- Strategic and operational leadership and management in maintaining the above principles, working as a multi-agency group across LBRuT to achieve the Board's objectives.
- Effective strategic governance of safeguarding at senior management level across all partner organisations.
- Public accountability for safeguarding arrangements and outcomes.
- Accountability for poor practice, robustly acting in ensuring these principles are maintained, taking action wherever and whenever necessary.

3. OBJECTIVES

What will the board do?

3.1 As a multi-agency Board, comprising of senior representatives, the Board will carry out the following key functions:

- Strategic leadership and oversight of adult Safeguarding arrangements in the Borough discharged through all statutory and non statutory partners.
- Oversight of the effective implementation of the Pan London Policy at a local level.
- Support and guide communities and organisations to ensure that the circumstances in which neglect and abuse occur in LBRuT are actively identified and prevented, thereby promoting the welfare and interests of vulnerable adults.
- Develop a robust overarching strategy for Safeguarding in LBRuT, within which all agencies set their own strategic and operational policy.
- Raise awareness, knowledge and understanding of abuse and neglect in order that communities and organisations know how to respond in an effective, coherent and timely way when safeguarding issues arise.
- Engage and encourage dialogue with intra and inter borough partnerships to achieve shared responsibility for the safety and welfare of all adults resulting in an effective response to the vulnerable adult.
- Ensure coordinated and timely operational processes, for identifying and investigating any incidents of abuse and protect vulnerable people.
- Ensure that vulnerable adults who use services that fall within the remit of the Board are safe and their care and treatment is appropriate to their needs.
- Ensure that each organisation has systems in place that evidence that they discharge their functions in ways that safeguard vulnerable adults.
- Work together as a Board to learn and share lessons learnt from national and local experience and research and to promote best practice by ensuring that such learning is acted upon.
- Develop systems to audit and evaluate the impact and quality of safeguarding work to aid continuous improvement of interagency practice, including lessons learned from practice.
- Develop and maintain a strong and evolving network of stakeholders including vulnerable adults, their carers and advocates.
- Undertake joint serious case reviews when it is confirmed or there is strong evidence to suggest that a vulnerable adult has died, been significantly harmed or put at risk as a result of abuse or neglect.

3.2 In order to achieve these objectives, organisations and agencies agree to:

- Work together for the prevention, identification, investigation and treatment of alleged suspected or confirmed abuse of vulnerable adults.
- Ensure that vulnerable adults have the same rights as others in the prosecution of criminal offences and pursuit of civil remedies.
- Develop and implement policies and procedures within a multi agency framework to protect vulnerable adults.

4. MEMBERSHIP
Who will attend?

4.1 The core membership of The Board will be:

- Paired/Reciprocal Chair
- Director of Adult & Community Services (LBRuT)
- Assistant Director of Commissioning Care Services (LBRuT)
- Head of Adult Safeguarding (LBRuT)
- Head of Performance & Quality Assurance (LBRuT)
- Detective Chief Inspector (Police)
- Head of Safeguarding, Adult Services (HRCH)
- Safeguarding Lead Nurse (Richmond CCG)
- Borough Service Director (SWL StG Mental Health NHS Trust)
- Deputy Director of Nursing (Kingston Hospital Trust)
- Board Lead for Clinical Services (Your Healthcare)
- Borough Commander Richmond (LFB)
- Community Safety Manager (CSP)
- Health & Partnerships Manager (RCVS)
- Assistant Chief Officer (Kingston & Richmond LDU)
- Cabinet Member

The Care Quality Commission will have representation on the Board, with a minimum requirement of attendance at at least one Board meeting per annum, though this will be in an observational, non-voting capacity only.

4.2 Appendix 1, "Statement of Commitment", sets out the role, function and responsibilities of being a Board Member.

4.3 ***Constituent Agencies***: Partner organisations will recognise the importance of securing effective leadership by nominating persons who are of seniority to be Board members, acting on their behalf.

4.4 ***Co-opted members***: As determined and required by the Board, it may co-opt other members as necessary. This will include:

- Senior lead for Safeguarding, and Safeguarding Co-ordinator to support the work of the board (NB these posts are under review and development).
- Chairs and nominated members of the Partnership working groups, and other subgroups of The Board.
- Secretariat support for The Board, to be provided by the Adult and Community Services Directorate, LBRuT

- Named officers, speakers, and organisations relevant to achieving the key priorities of the Board.

All attendees will be invited in a consultative capacity.

4.5 ***Observers:*** Subject to the approval of the Chairperson, the Board may agree to observers being in attendance.

4.6 ***Chair and Vice-Chair:*** The Director of Adult Social Services retains the statutory responsibility for the functioning of The Board. The Safeguarding Adults' Partnership Board will appoint an Independent Person as Chair, who will act with impartiality. The person appointed will occupy the 'office' for two years. A Vice Chair will be agreed as necessary.

5. **Induction & Training:** Training for Board Members will be provided for all new Board members together with an induction pack. Thereafter training will be provided as needed.

6. GOVERNANCE

6.1 The Board will report to the Health and Wellbeing Board on, at least an annual basis.

6.2 The Chairperson of the Board will be responsible for ensuring that an annual report of the Board is prepared concurrent with the municipal year and made publically available.

6.3 The annual report shall be published on the Council's website. It is the responsibility of all partner agencies to present the Annual Report to their respective senior management teams and constituted decision making bodies within 3 months of the report publication.

7. RELATIONSHIP TO OTHER BOARDS

How the Board and other groups and forums link up

7.1 The Board will ensure that there are appropriate representatives on the following boards and forums to represent and champion safeguarding:

- Richmond Health and Wellbeing Board
- Richmond Community Safety Partnership Group
- Richmond Clinical Care Governance Body
- Richmond Local Safeguarding Children's Board
- Richmond Domestic Abuse Forum
- MAPPA & MARAC
- Richmond Learning Disability Partnership Board.

It is the role of representatives to identify matters significant to the achievement of local safeguarding developments, represent the views and priorities of the Board, and report back milestones and outcomes.

8. BOARD SUBGROUPS AND REFERENCE GROUPS

8.1 The following shall be established as subgroups groups of The Board, with the Chair and membership recommended by The Board (and may be redefined as necessary by the Board):

- Learning and Development Subgroup
- Communications Subgroup
- Policy and Performance Subgroup
- Serious Case Review Subgroup

8.2 The subgroups will be accountable to the Board. Work undertaken will be commissioned by the Board and progress against targets set and outcomes identified will be reported to the Board, using the agreed template. The role of the groups will include:

- To consider new practice, policy and procedural issues and to propose and initiate appropriate action plans to address those issues.
- To analyse data and compile and present to the Board a quarterly quantitative and qualitative performance report.
- To consider the resource implications of safeguarding and make recommendations to the board.
- To set up time-limited task groups or task individuals to undertake specific tasks on policy, procedure and practice matters as necessary.
- To evaluate information presented through statistics, user surveys, DoH inspections etc and propose alterations to policies, procedures and practice to the Board for approval.
- To monitor the effectiveness of public information and communication regarding adult protection and to find ways of communicating to all.
- To monitor the effectiveness of training in increasing awareness, and in improving the effectiveness of protection planning and safeguarding interventions.
- To seek and collate the views of user and care stakeholders to inform best practice.

8.3 In addition, the Board will establish a reference groups for the purpose of capturing feedback from key stakeholders and informing developments.

9. FREQUENCY OF BOARD MEETINGS & MEETING MINUTES

9.1 The Board will meet at least 4 times in every year at such times as may be determined by the Chairperson. Dates will be set a year in advance.

9.2 Meetings will usually be in two parts: Part A will address the general business of the Board and minutes will be published; Part B will address confidential business of the Board and minutes will not be published. It is anticipated that Part B will deal with matters relating to, for example, Care Service Provision and the confidentiality aspect is designed to avoid any implications in respect of restrictions of trade.

9.3 Minutes of the meetings of The Board shall be taken by a secretary of the Directorate of Adult & Community Services LBRuT – with actions and timeframes duly identified.

9.4 The Chairperson of the meeting shall move that the minutes of the previous meeting shall be approved as a correct record.

9.5 Minutes of the Board and the Annual Report will also be forwarded to the Chairs of the following strategic planning forums, to advise on issues arising and inform cross strategic planning as set out in 6.1 above:

- The Local Safeguarding children's Board
- The Health and Wellbeing Board.

STATEMENT OF COMMITMENT

Each member of the LBRuT Safeguarding Adults Partnership Board (The Board) gives a commitment to the following:

Representation

Represent an agency, organisation or representative group of people with full authority.

In doing so to raise issues on their behalf, contribute to discussion and debate and ensure a dissemination of information back to that representative group, agency or organisation.

To ensure that the representative group, agency or organisation they represent engages with the Safeguarding and Adult Protection agenda and embeds safe practice in their organisation, agency or representative group ensuring positive leadership and stewardship of the issues.

Values

Upholds the principles and aims of the Board as set out in the Terms of Reference, ensuring that vulnerable adults are protected from abuse, working with partners to safeguard them through strategic leadership within the representative group, agency or organisation they represent.

Attendance

To attend every Board meeting or to arrange for a suitable representative to act on their behalf (and who is able to act with full authority) at any meeting they are unable to attend.

Annual Report

Make a contribution, as necessary, to the Board's Annual Report

SIGNED:	
PRINT NAME:	
REPRESENTING:	
DATE:	

CONFIDENTIALITY STATEMENT

The Board is convened under “no secrets” guidance and will conform to equal opportunities and anti discriminatory criteria. All people attending must respect the confidentially of the issues discussed and in particular where case examples are discussed: these issues are confidential and should not be disclosed to other people without the expressed permission of the Chair.

It is noted that for wider learning, information discussed at The Board does need to be shared within the wider community but this must always be done retaining anonymity in relation to named individuals, services or agencies. Where Board members are uncertain as to what can be shared this needs to be determined at The Board and agreed as part of the minutes.

It is recognised that, where there are issues relating to clinical and professional accountability, then individual Board members may need to raise this within the agency they represent. It is expected that where this situation arises it will be raised and agreed by the Board as part of the business of that meeting.

All Board members are required to uphold both the Statement of Commitment and Confidentiality Statement

SIGNED:	
PRINT NAME:	
REPRESENTING:	
DATE:	

Appendix 2: Glossary & Abbreviations

ADASS	Association of Directors of Adult Social Services
ASB	Anti-Social Behaviour
ASC	Adult Social Care
BIA	Best Interest Assessors
CPS	Crown Prosecution Service
CSP	Community safety Partnership
CVS	Council for Voluntary Service
DoLS	Deprivation of Liberty Safeguards (Code of Practice to supplement the MCA 2005)
HRCH	Hounslow and Richmond Community Healthcare
IDVA	Independent Domestic Violence Advocate
IMCA	Independent Mental Capacity Advocate
LBRuT	London Borough of Richmond upon Thames
MAPPA	Multi-Agency Public Protection Arrangements (responsible for protecting the public from offenders)
MARAC	Multi-Agency Risk Assessment Conference (responsible for reducing the risk of domestic violence)
MCA	Mental Capacity Act 2005
PPO	Public Protection Officer
PREVENT	The Prevent strategy, launched in 200, seeks to stop people becoming Terrorists or supporting terrorism
RCVS	Richmond Community Voluntary Service
SAM	Safeguarding Adult Manager
SAPB	Safeguarding Adults Partnership Board
SIGG	Serious Incident Governance Group

Appendix 3: SAFEGUARDING ADULTS PARTNERSHIP BOARD MEMBERS

Member	Position	Contact Details
Dawn Warwick (Partnership Chair)	Director of Adult Services L.B. Wandsworth	dwarwick@wandsworth.gov.uk
Cathy Kerr	Director of Adult & Community Services L.B. Richmond upon Thames	cathy.kerr@richmond.gov.uk
Derek Oliver	Assistant Director of Adult & Community Services L.B. Richmond upon Thames	derek.oliver@richmond.gov.uk
Andrea Knock	Head of Safeguarding Hounslow & Richmond Community Health	andrea.knock@rtpct.nhs.uk
Carol Stewart	Head of Workforce Development L.B. Richmond upon Thames	Carol.Stewart@richmond.gov.uk
Sarah Haspel	Service Director South West London & St George's Mental Health Trust	Sarah.Haspel@swlstg-tr.nhs.uk
Gill Ford	Head of Performance & Quality Assurance L.B. Richmond upon Thames Joint Chair Policy & Performance Sub Group	g.ford@richmond.gov.uk
Kathryn Williamson	Health & Partnership Manager Richmond Council of Voluntary Services	kathrynw@richmondcvs.org.uk
Jackie Bennett	Head of Service Safeguarding L.B. Richmond upon Thames	jackie.bennett@richmond.gov.uk
Debra Towns	Chief Inspector, Community & Partnership Richmond Police	Debra.Towns@met.pnn.police.uk
Peter Warburton	Safeguarding Lead Nurse Richmond Clinical Commissioning Group	Peter.warburton@richmond.gov.uk

Member	Position	Contact Details
Fiona Hegarty	Board Lead for clinical Services (Long Term Care)	fiona.hegarty@yourhealthcare.org
Andy Cane	Borough Commander London Fire Brigade	Andy.cane@london-fire.gov.uk
James Jolly	Assistant chief Officer, London Probation Trust	James.jolly@london.probation.gsi.gov.uk
Ken Emerson	Senior Advice & Assessment	k.emerson@richmond.gov.uk
Cllr David Marlow	Cabinet member for Adult Services, Health & Housing	cllr.dmarlow@richmond.gov.uk