Havering
Safeguarding Adults Board

Annual Report

April 2018 – March 2019

Contents

Introduction by Independent Chair, Brian Boxall

The Havering Safeguarding Adults Board (SAB) had a busy year during 2018/19, including commissioning several Safeguarding Adult Reviews (SARs). The SAB partner agencies, individually and collectively, must learn from these tragic cases and work together strategically to ensure improvement in the areas highlighted by the SAR findings, including assessments, information sharing, appropriate completion of mental capacity assessments and increased professional curiosity.

The SAB will ensure the learning from these SARs is taken on board and will produce a comprehensive action plan capturing the review recommendations. This plan will be kept under review to track how subsequent improvements impact positively upon outcomes for vulnerable adults in Havering.

This learning will be supported by the SAB's commitment to Making Safeguarding Personal (MSP), which is the underlining principal of the Care Act 2014. The board have been working to develop a way of working that shares national best practice, to embed MSP into the work across individual agencies and the wider partnerships.

Despite increasing pressures, partner agencies have continued to support the SAB and its work to improve provision for vulnerable adults in Havering. I would like to thank all the partners for their commitment.

During 2019/20 the SAB is looking to develop collaborative working with our neighbours in Barking & Dagenham and Redbridge. Sharing of review learning across the tri-borough will be our fist collaboration in 2019.

Our Safeguarding Week in 2018 proved once again to be a big success, and for the first time the Safeguarding Conference was produced jointly by the SAB and the Safeguarding Children Board, focusing on transition of young adults. We will be looking to repeat Safeguarding Week in 2019.

I will continue to challenge SAB members to ensure that vulnerable adults in Havering continue to be safeguarded.

Brian Boxall
Independent Chair, Havering SAB

Role and Core Duties of the Havering Safeguarding Adults Board

Care and Support Statutory Guidance 2018 (points 14.133 – 14.141) defines the role and core duties of a Safeguarding Adults Board:

- Each local authority must set up a Safeguarding Adults Board (SAB). The main objective of the SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria for care and support.

- The SAB has a strategic role that is greater than the sum of the operational duties of the core partners. It oversees and leads adult safeguarding across the locality and will be interested in a range of matters that contribute to the prevention of abuse and neglect. These will include the safety of patients in its local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services. The SAB will need intelligence on safeguarding in all providers of health and social care in its locality (not just those with whom its members commission or contract). It is important that SAB partners feel able to challenge each other and other organisations where it believes that their actions or inactions are increasing the risk of abuse or neglect. This will include commissioners, as well as providers of services.

- The SAB can be an important source of advice and assistance, for example in helping others improve their safeguarding mechanisms. It is important that the SAB has effective links with other key partnerships in the locality and share relevant information and work plans. They should consciously cooperate to reduce any duplication and maximise any efficiency, particularly as objectives and membership is likely to overlap.

- A SAB has 3 core duties:

    - it must publish a strategic plan for each financial year that sets out how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement, and the SAB must consult the local Healthwatch organisation. The plan should be evidence based and make use of all available evidence and intelligence from partners to for and develop its plan;

    - it must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the

strategy as well as detailing the findings of any Safeguarding Adults Reviews and subsequent action;

- it must conduct any Safeguarding Adults Reviews in accordance with Section 44 of the Care Act.

- Safeguarding requires collaboration between partners in order to create a framework of inter-agency arrangements. Local authorities and their relevant partners must collaborate and work together as set out in the co-operation duties in the Care Act and, in doing so, must, where appropriate, also consider the wishes and feelings of the adult on whose behalf they are working.

- Local authorities may cooperate with any other body they consider appropriate where it is relevant to their care and support functions. The lead agency with responsibility for coordinating adult safeguarding arrangements is the local authority, but all the members of the SAB should designate a lead officer. Other agencies should also consider the benefits of having a lead officer for adult safeguarding.

- Each SAB should:

  - identify the role, responsibility, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of adults;
  - establish ways of analysing and interrogating data on safeguarding notifications that increase the SAB's understanding of prevalence of abuse and neglect locally that builds up a picture over time;
  - establish how it will hold partners to account and gain assurance of the effectiveness of its arrangements;
  - determine its arrangements for peer review and self-audit;
  - establish mechanisms for developing policies and strategies for protecting adults which should be formulated, not only in collaboration and consultation with relevant agencies but also take account of the views of adults who have needs for care and support, their families, advocates and carer representatives.
  - develop preventative strategies that aim to reduce instances of abuse and neglect in its area;
  - identify types of circumstances giving grounds for concern and when they should be considered as a referral to the local authority as an enquiry;
  - formulate guidance about the arrangements for managing adult safeguarding, and dealing with complaints, grievances and

processional and administrative malpractice in relation to safeguarding adults;
    - develop strategies to deal with the impact of issues of race, ethnicity, religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect;
    - balance the requirements of confidentiality with the consideration that, to protect adults, it may be necessary to share information on a 'need-to-know' basis;
    - identify mechanisms for monitoring and reviewing the implementation and impact of policy and training;
    - carry out safeguarding adult reviews and determine any publication arrangements;
    - produce a strategic plan and an annual report;
    - evidence how SAB members have challenged one another and held other boards to account;
    - promote multi-agency training and consider any specialist training that may be required. Consider any scope to jointly commission some training with other partnerships, such as the Community Safety Partnership.

- Strategies for the prevention of abuse and neglect is a core responsibility of a SAB and it should have an overview of how this is taking place in the area and how this work ties in with the Health and Wellbeing Board's, Quality Surveillance Group's (QSG), Community Safety Partnership's and CQC's stated approach and practice. This could be about commissioners and the regulator, together with providers, acting to address poor quality care and the intelligence that indicates there is risk and care may be deteriorating and becoming abusive or neglectful. It could also be about addressing hate crime or anti-social behaviour in a particular neighbourhood. SAB will need to have effective links and communication across a number of networks in order to make this work effectively.

- Within the context of the duties set out at paragraph 14.2, safeguarding partnerships can be a positive means of addressing issues of self-neglect. The SAB is a multi-agency group that is the appropriate forum where strategic discussions can take place on dealing with what are often complex and challenging situations for practitioners and managers as well as communities more broadly.

Purpose of the Annual Report

As directed in *The Care Act 2014* (section 43, schedule 2), a Safeguarding Adults Board must publish an annual report on:

- what it has done during that year to achieve its objective;
- what it has done during that year to implement its strategy;
- what each member has done during that year to implement its strategy;
- the findings of Safeguarding Adults Reviews which have concluded in that year (whether or not they began in that year);
- the Safeguarding Adults Reviews which are ongoing at the end of the year (whether or not they began in that year);
- what it has done during the year to implement the findings of Safeguarding Adults Reviews; and
- where it decides during the year not to implement a finding of a Safeguarding Adults Review, and the reasons for that decision.

Further direction on Safeguarding Adults Board annual reports is provided in *Care and Support Statutory Guidance 2018* (point 14.157), which lists the following points for consideration:

- evidence of community awareness of adult abuse and neglect and how to respond;
- analysis of safeguarding data to better understand the reasons that lie behind local data returns and use the information to improve the strategic plan and operation arrangements;
- what adults who have experienced the process say and the extent to which the outcomes they wanted (their wishes) have been realised;
- what front line practitioners say about outcomes for adults and about their ability to work in a personalised way with those adults;
- better reporting of abuse and neglect;
- evidence of success of strategies to prevent abuse or neglect;
- feedback from local Healthwatch, adults who use care and support services and carers, community groups, advocates, service providers and other partners;
- how successful adult safeguarding is at linking with other parts of the system, for example children's safeguarding, domestic violence, and community safety;
- the impact of training carried out in this area and analysis of future need; and
- how well agencies are co-operating and collaborating.

Havering Safeguarding Adults Board Structure

Havering Safeguarding Adults Board Membership

Agencies represented on the HSAB:

Local Demographics and Safeguarding Performance Data

Havering
LONDON BOROUGH

- Havering is the 3rd largest borough in London
- With a growing population
- It has poor connectivity with public transport and high car ownership
- Havering has pockets of Deprivation, but is a relatively affluent borough
- Busy night time economy, 22% ASB crime occurs in Romford town centre

Population, 2018 - 2023

Age	2018	2023	% Change
All Ages	257810	276645	7.3 %
18-64	153833	163262	6.1 %
0-17	57541	63085	9.6 %
65+	46436	50298	8.3 %

257,810 residents
A borough with a growing population - the oldest in London

46,418 over 65s
The Borough holds the oldest population in London with the median age of 40 years

13.9% one person households aged 65+

52% Female

48% Male

13.8% BME
Least diverse but BME increasing to over 20% by 2027

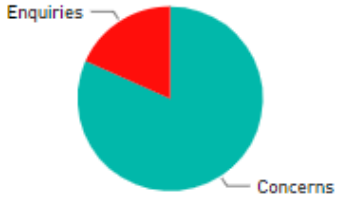
Havering
Safeguarding Adults Board

Havering
LONDON BOROUGH

Safeguarding Concerns

Concerns & Enquiries

The number of safeguarding concerns received in 2018-19 increased by 15.9% from 4062 to 4706 in comparison to 2017-18. Whilst the number of enquiries increased by 8.9% .



Gender

Individuals involved in a safeguarding concern

45% Male

55% Female

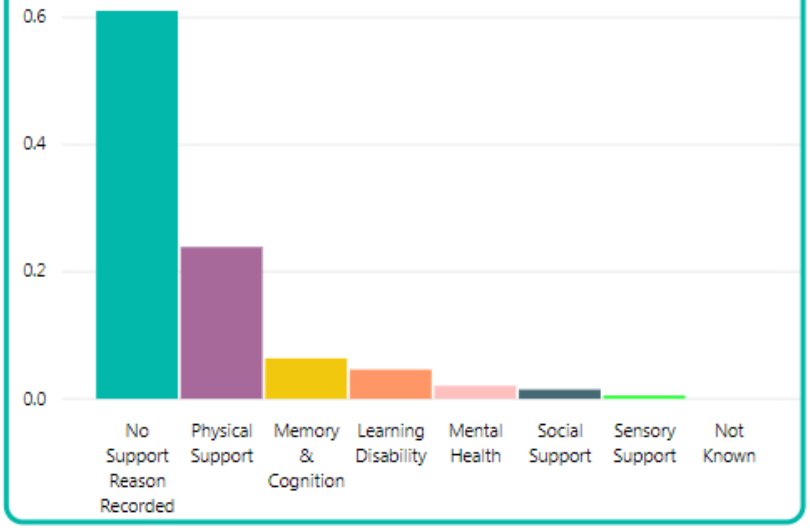
Ethnicity

69.7% of individuals involved in a safeguarding concern were white

6.8% of individuals involved in a safeguarding concern were Black Asian or Other minority groups

23.5% of individuals involved in a safeguarding concern did not declare their ethnicity

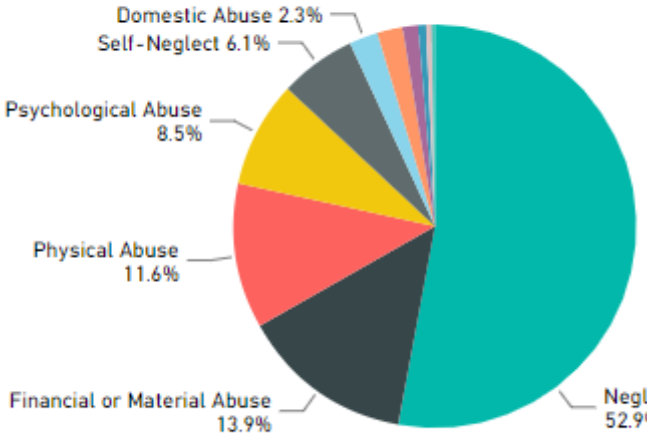
Primary Support Reason



Havering Safeguarding Adults Board

Concluded Safeguarding Enquiries

Type of Abuse

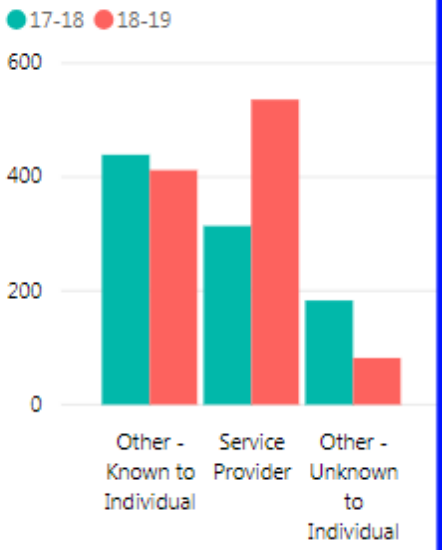


The most common types of abuse were:

52.9% Neglects & Omissions
13.9% Financial or Material
11.6% Physical

Source of Abuse

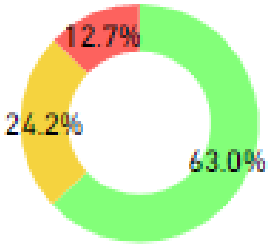
The number of concluded enquiries in 2018-19, where the source of abuse was the Service Provider, increased by **70.7%** when compared to 17-18. Where the source was Other - Known & Unknown, these decreased compared to the previous year



Location of Abuse

The highest proportion, **47%**, of location where abuse took place was in a person's own home. This was follwed by **36%** in a Residential Care Home setting.

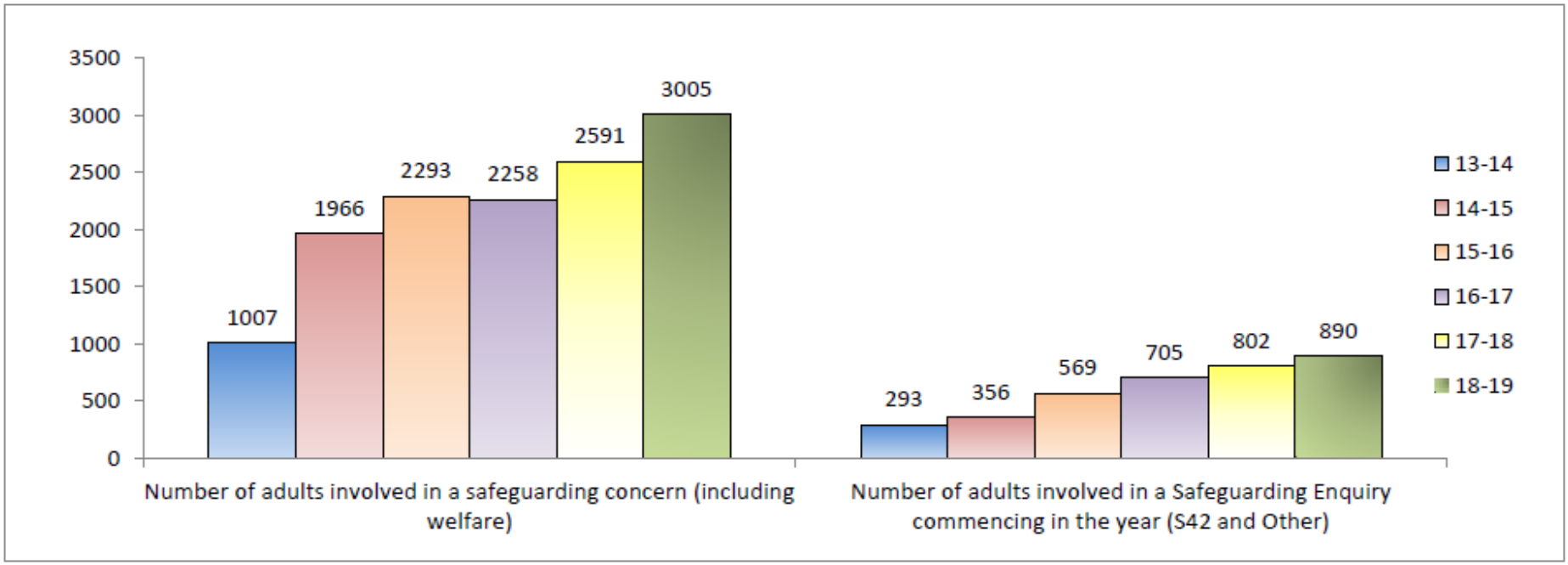
Risk



In cases where action was taken **87.2%** of risks were reduced or removed

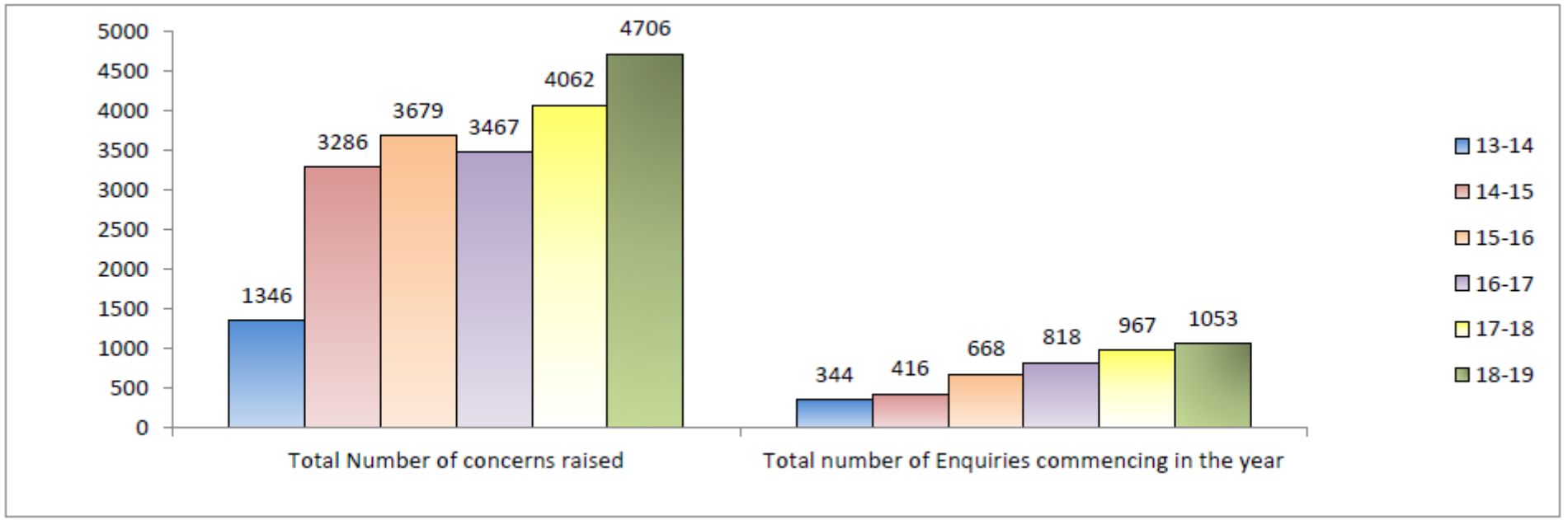
Havering Safeguarding Adults Board

	13-14	14-15	15-16	16-17	17-18	18-19	% increase from 17-18 to 18-19	% increase from 13-14 to 18-19
Number of adults involved in a safeguarding concern (including welfare)	1007	1966	2293	2258	2591	3005	16.0%	198.4%
Number of adults involved in a Safeguarding Enquiry commencing in the year (S42 and Other)	293	356	569	705	802	890	11.0%	203.8%



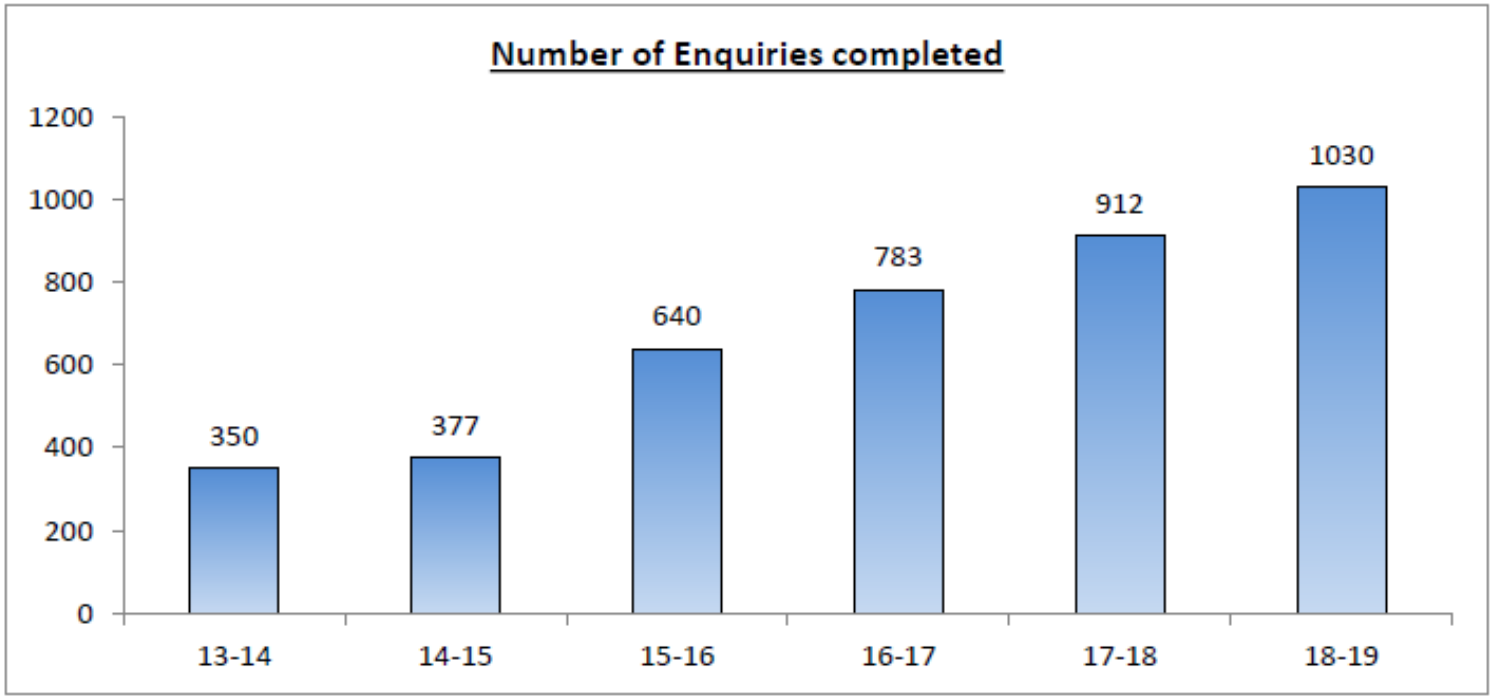
Havering
LONDON BOROUGH

	13-14	14-15	15-16	16-17	17-18	18-19	% increase from 17-18 to 18-19	% increase from 13-14 to 18-19
Total Number of concerns raised	1346	3286	3679	3467	4062	4706	15.9%	249.6%
Total number of Enquiries commencing in the year	344	416	668	818	967	1053	8.9%	206.1%



Havering
Safeguarding Adults Board

	13-14	14-15	15-16	16-17	17-18	18-19	% increase from 17-18 to 18-19	% increase from 13-14 to 18-19
Number of Enquiries completed	350	377	640	783	912	1030	12.9%	194.3%

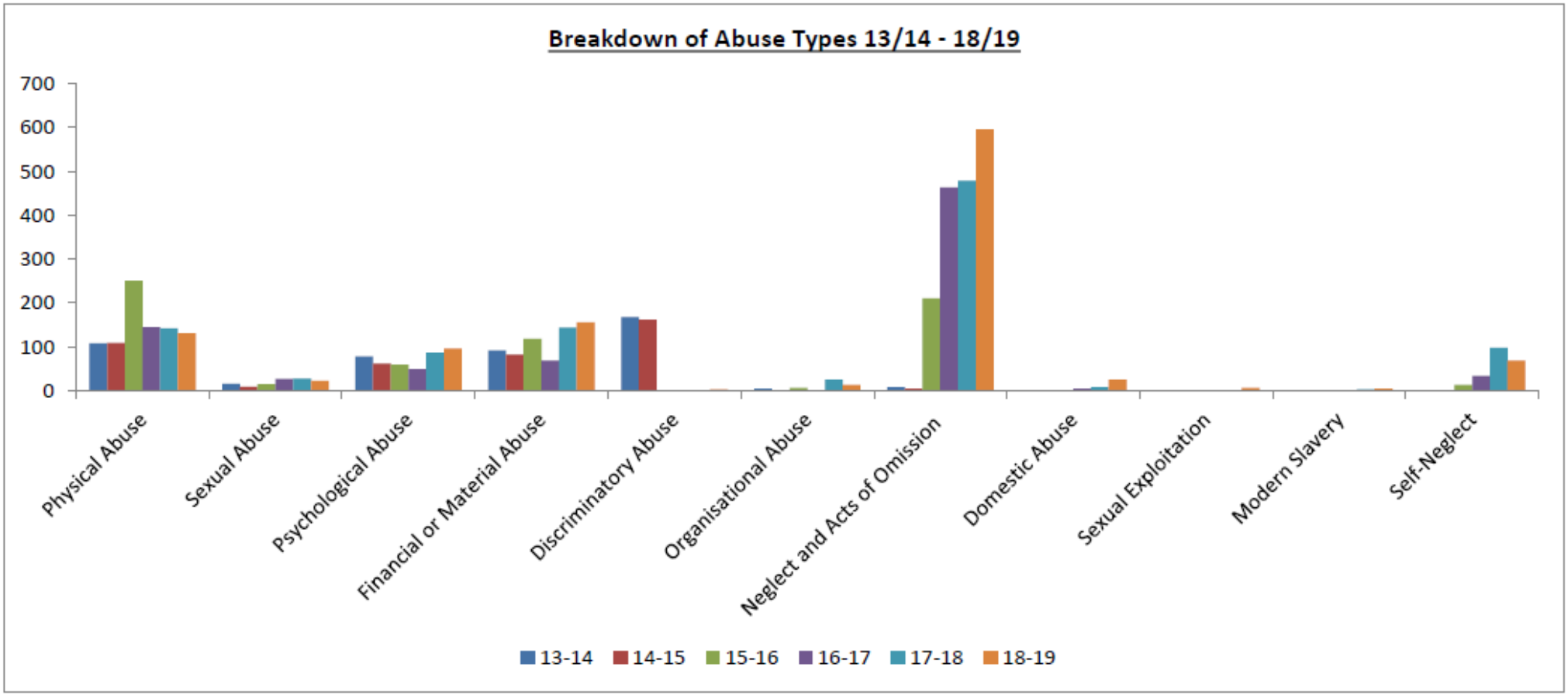


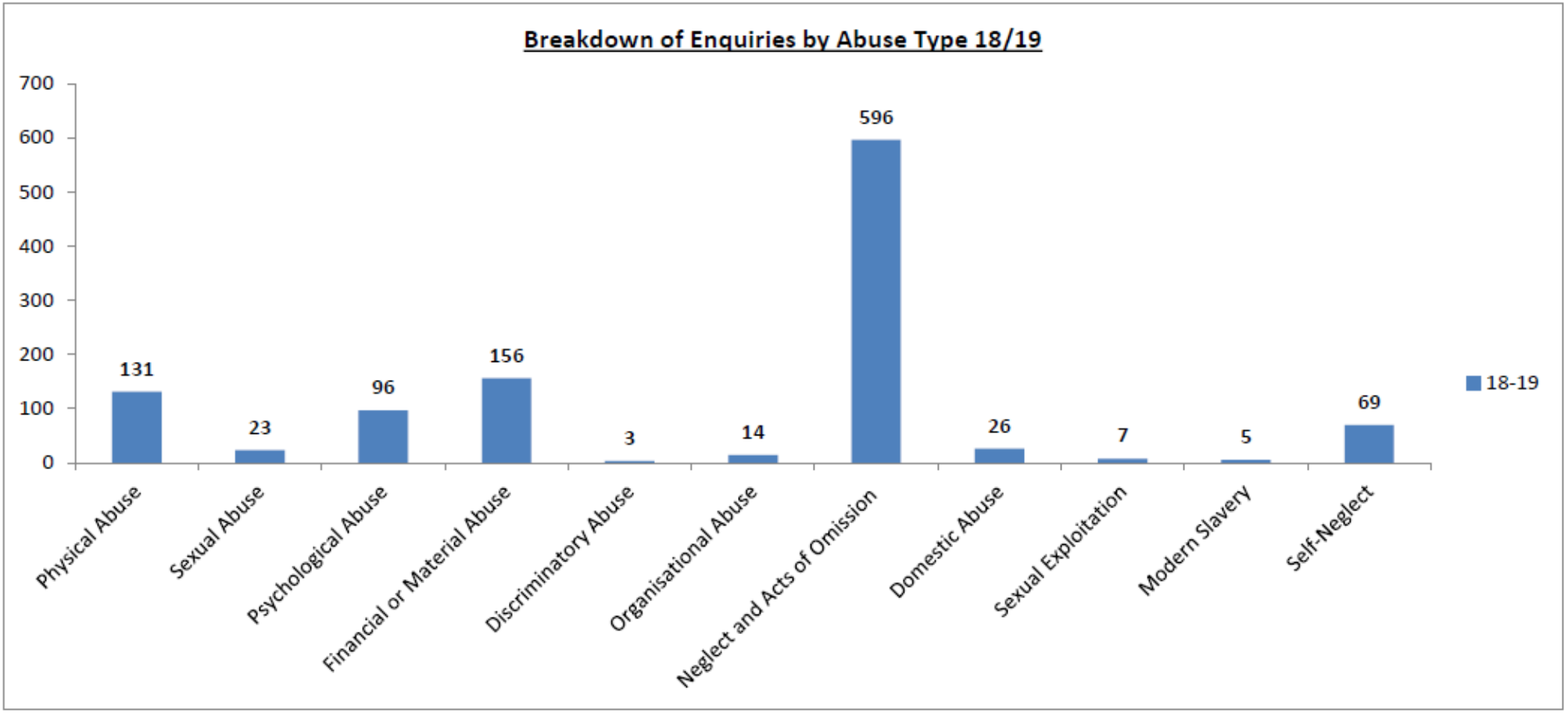
Completed Enquiries by Abuse Type

	13-14	14-15	15-16	16-17	17-18	18-19	% increase from 17-18 to 18-19	% increase from 13-14 to 18-19
Physical Abuse	108	109	251	145	142	131	-7.7%	21.3%
Sexual Abuse	16	9	15	27	28	23	-17.9%	43.8%
Psychological Abuse	78	62	60	49	87	96	10.3%	23.1%
Financial or Material Abuse	92	83	118	69	144	156	8.3%	69.6%
Discriminatory Abuse	168	162	1	1	1	3	200.0%	-98.2%
Organisational Abuse	5	2	7	1	25	14	-44.0%	180.0%
Neglect and Acts of Omission	8	5	211	463	479	596	24.4%	7350.0%
Domestic Abuse	N/A	N/A	1	5	8	26	225.0%	N/A
Sexual Exploitation	N/A	N/A	0	1	1	7	600.0%	N/A
Modern Slavery	N/A	N/A	0	0	3	5	66.7%	N/A
Self-Neglect	N/A	N/A	13	34	98	69	-29.6%	N/A
Total	475	432	677	795	1016	1126	10.8%	113.9%

Please be aware that some enquiries may have muplitple abuse types

Domestic Abuse, Sexual Exploitation, Modern Slavery and Self Neglect only became abuse types in 2015/16


Breakdown of Abuse Types 13/14 - 18/19
700
600
500
400
300
200
100
0
Physical Abuse
Sexual Abuse
Psychological Abuse
Financial or Material Abuse
Discriminatory Abuse
Organisational Abuse
Neglect and Acts of Omission
Domestic Abuse
Sexual Exploitation
Modern Slavery
Self-Neglect
13-14
14-15
15-16
16-17
17-18
18-19



Please be aware that some enquiries may have multiple abuse types

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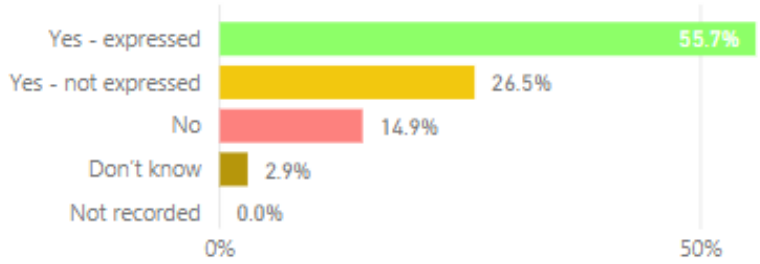
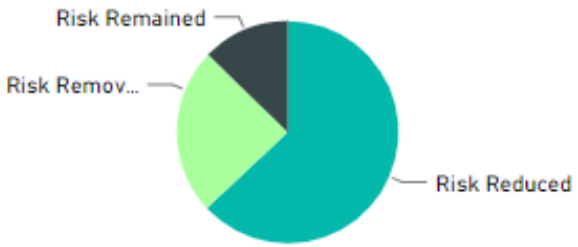
Making Safeguarding Personal

% MSP Asked



82.2% of adults at risk or their representative were asked about their desired outcomes.

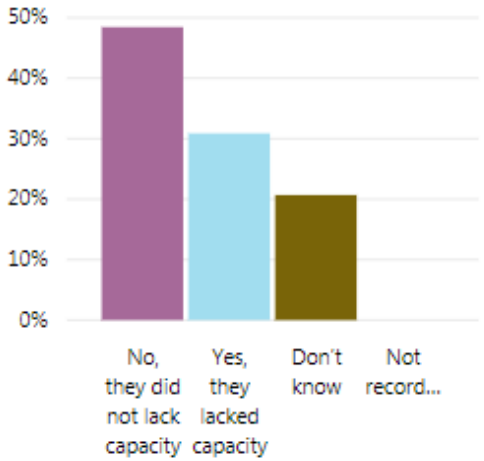
% Risk Outcomes



95% of desired outcomes were either Fully or Partially achieved

Mental Capacity

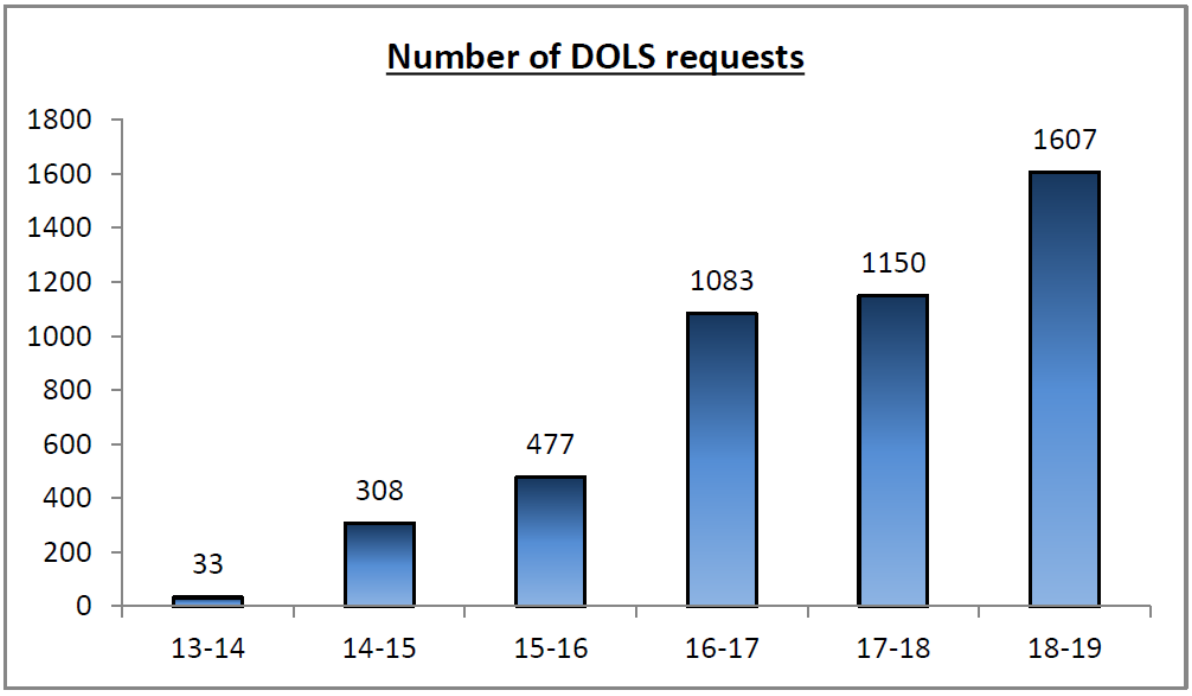
The percentage of completed enquiries where the adult at risk had an assessment of their Mental Capacity was **79.3%**, with **30.8%** receiving an outcome of lacking capacity



Havering Safeguarding Adults Board

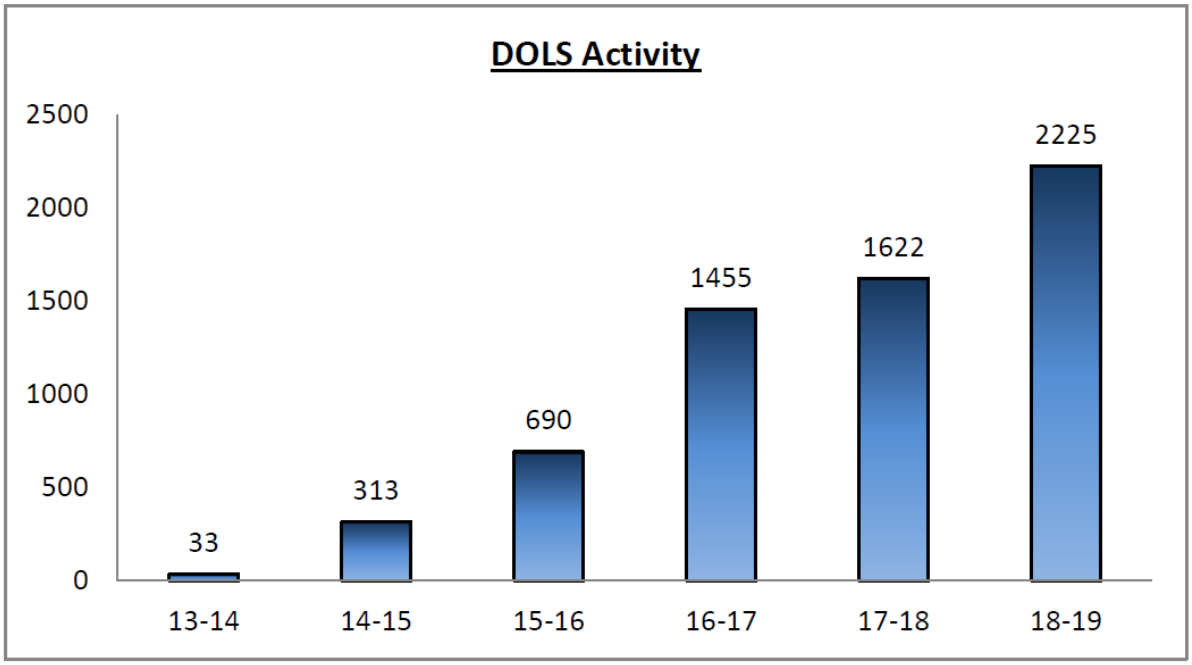
Deprivation of Liberty Safeguards (DoLS)

	13-14	14-15	15-16	16-17	17-18	18-19	%Increase 17/18 to 18/19
Number of DOLS requests	33	308	477	1083	1150	1607	39.7%



DOLS Activity

	13-14	14-15	15-16	16-17	17-18	18-19	%Increase 17/18 to 18/19
DOLS Activity	33	313	690	1455	1622	2225	37.2%



The above chart shows the throughput within DoLS, this includes those who requested as well as those who were subject to a DoLS during the year

Safeguarding Adults Reviews

During 2018/19, the Havering SAB actively progressed three Safeguarding Adults Reviews (SARs), into the deaths of HM, GC and CM.

A multi-agency learning event to consider all three of these SARs is scheduled for early in 2019/20, with the aim of producing a combined action plan that responds to the recommendations from each review.

A decision has been made to undertake a further SAR, into the death of SW, during 2019/20.

The death of HM

HM was a 91-year old white British woman who died in January 2017 during an urgent hospice admission. HM had a medical diagnosis of dementia and a history of physical ill health. She was bedbound and reliant on support for all her care and daily living tasks.

HM was believed to lack capacity to make decisions regarding her care and support needs. HM's care was provided by Personal Assistants (PAs) via a Direct Payment.

Assessment documentation refers to HM's dementia as being 'advanced' in January 2015 and 'severe' in April 2015. Over this period, she was admitted to hospital on a number of occasions.

In December 2016, District Nurses raised a safeguarding concern after seeing HM that day, prompted by concerns being raised to the GP by HM's visiting granddaughter.

The District Nurses found HM to have 11 pressure ulcers at grade 4, some necrotic, with one measuring 12cm x 7cm. This resulted in the urgent hospice admission in January 2017, during which HM sadly passed away.

The subsequent Coroner's report stated that the pressure areas were a contributory factor in her death. No concerns had been raised or medical attention sought prior to the District Nurses' visit in December 2016.

The SAR into the death of HM resulted in the following recommendations for the SAB:

- All agencies need to promote understanding of key statutory duties and powers under the Care Act 2014 with particular focus on Carers Assessments and the differences between reviews, reassessment and criteria for safeguarding. The Board may like to consider how agencies can demonstrate such assurance on the application of this understanding into practice and outcomes for people with eligible care and support needs.

- The Board may like to seek assurance on compliance within agencies on application of the Mental Capacity Act to ensure that formal capacity assessments are being undertaken where required and recognising the requirement for advocacy for people with care and support needs to ensure their views, wishes and feelings are appropriately represented and to ensure person-centred interventions. This is inclusive of the consideration of advocacy where potential conflicts of interests arise regardless of the person's capacity.

- The Board may like to seek assurance that all agencies have a quality assurance mechanism to measure effectiveness of dynamic and holistic risk assessment and its subsequent management within their own organisation and how this interface impacts within a multi-agency framework.

- The Board should seek to assurance that there are robust information sharing protocols which are reflective of balancing informed consent, mental capacity, public interest and vital interests and that agencies have mechanisms in place for disseminating changes in policy, procedures and protocols. Assurance is required that referral pathways are streamlined and are outcome not process focused.

- The Board may wish to consider how it can promote a positive culture of professional curiosity which supports effective multi-agency working and collaboration. This should be inclusive of its workforce development strategy and focus on achieving person-centred interventions whilst discharging duty of care.

- In relation to the identified issues and developed action plans resulting from this review, the Board may wish to determine whether effective quality assurance exists to maintain standards of recording that evidences defensible practice and how IT infrastructures support this, inclusive existing local developments (Health IT project) and other key stakeholder agencies i.e. ASC and Housing.

- Whilst it is a statutory duty to offer direct payments where appropriate, professionals and organisations retain a duty of care to ensure eligible needs

are being met regardless of the commissioning responsibility by an individual or their representative. Further assurance that professionals and organisations retain a duty of care to ensure eligible needs are being met where direct payments are in place and to monitor risks in order to identify any shortfalls or arising safeguarding issues would be beneficial.

- As a result of this review, all agencies have provided action plans to address both identified practice and systems issues within this case. It is recommended that the Board ensure that they have a robust mechanism to monitor the implementation of Individual Action Plans and to evaluate the subsequent impact as a result of this learning.

- In relation to the police investigation into suspected fraud by carers for HM following a submission of evidence to the Crown Prosecution Service (CPS) it was deemed to not have reached the evidential threshold for a realistic prospect of conviction. The Board may wish to review what the evidential difficulties were surrounding time sheets and practical record keeping amongst partners to ensure that future cases are as evidentially tight as possible and not a stumbling block to a successful Criminal Justice (CJ) outcome. This may also act as a deterrent going forward.

The death of CM

CM was 93 years old when he took his own life at his home on October 2017.

CM and his elderly, frail wife were known to a wide range of hospital and community health and care services because of their longstanding health issues and their need for care and support.

In the 12 months prior to his death, CM had eight inpatient admissions to hospital through calls to Emergency Services. In the majority of these incidents, the presenting issues were CM's physical problems.

As well as his chronic physical problems, CM had a diagnosis of depression with episodes going back to when he was in the armed services in the Second World War.

He disclosed to members of his family and to Health and Social Care professionals his low mood and his wish to end his life. The evidence presented to the review indicated that there were recent incidents of self-harm and others dating back to his time in military service.

A protective factor for CM in terms of his low mood and providing a reason for living was considered to be the presence of his wife and family. The view was shared by CM himself, his family and health and Social Care professionals.

Following a fall at home in October 2017, CM was taken to the Emergency Department by London Ambulance Service and subsequently admitted as an inpatient.

Three days later, CM was discharged from the hospital to go home. In order to facilitate his discharge home, support services were recommenced and the family informed of the planned discharge.

CM's wife had been admitted as an inpatient on the morning of the same day as CM's discharge from hospital. She had been taken by ambulance to the Emergency Department the night previously. She remained as an inpatient until November 2017.

Following his discharge from hospital, CM lived at home with support from his family and Westminster Care visiting four times daily until his death 5 days after his discharge.

The SAR into the death of CM resulted in the following recommendations for the SAB:

- Agencies should consider how best to develop guidance and managerial oversight of cases to ensure that health and social care professionals identify patients with complex needs so that physical and mental health issues can be addressed holistically and systemically.

- The required competencies for different Health and Social Care staff regarding mental health issues should be identified at both a strategic and individual level.

- Training for Health and Social Care staff on the mental health competencies appropriate for their role should be provided wherever possible on a multi-agency basis.

- Where there are complex needs identified a health and social care teams, their roles and responsibilities, access and availability should be developed, distributed and maintained.

- A multi-agency information sharing event should be scheduled for Safeguarding Week.

- There should be a review of the guidance of the involvement of the Enhanced Mental Health Liaison Service when the discharge of an in-patient with mental health needs is being planned.

- Consideration should be given for the development of a protocol for the sharing of risk assessments across agencies.

- As an interim measure and in the absence of a technological solution, consideration should be given for the development of protocols for the key staff to regularly share information and records.

- A process whereby frequent attenders to the Emergency Department and inpatient services are identified in 'real time' and interventions proactively planned should be considered.

- A review of the relevant policies and procedures should take place to ensure that the patient's consent as to whom they want to be involved and informed is regularly reviewed and documented.

- The regular audit of adult safeguarding practice that takes place across all agencies should be amended to ensure that Health and Social Care professionals have the appropriate and up-to-date levels of knowledge and competencies.

- The concerns highlighted in this review should be cross-referenced with other recent SARs and where appropriate to inform its findings and recommendations.

- Multi-agency training that supports Health and Social Care practitioner to develop and utilise their skills of professional curiosity should be developed.

The death of GC

GC was born in London in the 1920s. His occupation had been service in the Merchant Navy and Docker. GC was married until the death of his wife, CC, in 2015.

GC was described by most people that worked with him as 'a pleasant, very independent gentleman that chose to live an unconventional lifestyle all his life'.

The house he occupied with his wife, until she entered nursing care, did not have central heating or hot water, although it appears that different room in the house (the room his wife occupied) were furnished and modified with heating. GC slept in a

separate downstairs room from his wife, which a visiting Social Worker described as ‘full of boxes and bedding and it appeared that he was living and sleeping in a box’.

Alongside this atypical lifestyle, GC cared for his wife prior to her entry into nursing care due to being bedbound. At times, GC’s level of hygiene presented difficulties in terms of his wife’s care, particularly around meal preparation. As a result, he was encouraged not to support her and to allow carers and their daughter to provide the support required.

GC was first known to Adult Social Care in July 2007, when his family requested a care package on discharge from hospital.

In October 2013, Adult Social Care received a safeguarding alert in respect of financial abuse. At the same period, the Social Worker investigating the safeguarding alert discussed the home conditions with the allocated Social Worker for his wife (who was receiving four calls a day for personal care and Activities of Daily Living) and the family. The family explained that the unkempt appearance of GC had endured throughout his lifetime, with a reluctance to wash and change clothes.

In January 2014, concerns were again raised with Adult Social Care in relation to the home circumstances and GC’s unhygienic lifestyle. Anxieties were further compounded in relation to GC’s safety, which was discussed with the GP, following reports that GC had left the gas on in the home. GC once again declined any assistance.

In December 2014, the GP visited GC and was concerned that he might be experiencing carbon monoxide poisoning, although this was proved negative by paramedics. Eventually GC was persuaded to attend hospital. This admission to hospital then allowed GC’s family to clean the property in his absence.

This admission to hospital is recorded as required for a primary diagnosis of ‘dehydration and self-neglect’. This is the first occasion self-neglect is formally recognised.

Following discharge from hospital on in March 2015, CC was placed in a nursing home. She died in June 2015.

In November 2015, the homecare agency reported to the Emergency Duty Team that GC, who was known to use candles at home, was also burning tissue in a cup (there is no explanation why, or a note of any enquiries into this being made by the homecare agency). Adult Social Care enquired whether GC’s home had a smoke alarm fitted, and whether this was functional. The homecare agency were not able to

provide information related to a fire alarm at the time and were asked by Adult Social Care to check at the next visit. The homecare agency records indicate that GC was asked for permission to install but that he refused to allow fitting.

In January 2016, the homecare agency raised further fire risk concerns with adult Social Care. The homecare agency report that, in extreme cold whether, GC was using an electric fan heater, which was noted to be a fire hazard, even though he had an oil-filled radiator available for use, which was noted to be safer but considered by him to be more expensive than using electricity. The homecare agency also reported that GC had been placing the electric fan heater exceptionally close to his quilt, upon which scorch marks had been noticed. The homecare agency described having proactively moved the electric fire away from his bedding materials, but that GC appeared to move it back again.

On 11 March 2016, GC died in a house fire.

The SAR into the death of GC resulted in the following recommendations for the SAB:

- The SAB should ensure that the self-neglect policy had an automatic care pathway referral route to the London Fire Brigade.
- The SAB should regularly audit the interagency co-operation and care plans for individuals recognised as self-neglect.
- The SAB should ensure that processes to recognise ‘complex and high risk’ cases have a common escalation process utilised by all agencies.
- The SAB should ensure that there is a common escalation process for ‘complex and high risk’ cases across agencies.
- The new risk assessment form should be evaluated for its utility and consistent application.
- The recommendation of a specific policy for risk assessment should be evaluated.
- The SAB should consider if further training is required related to self-neglect and mental capacity.
- All agencies should reinforce the necessity for timely and accurate recording of interaction with clients.

- The SAB might consider a working group to reflect on the range of legal approaches to self-neglect.

- Adult Social Care and NELFT will identify the scale of self-neglect cases and then consider if a multi-agency team should be established to address this issue.

Havering Safeguarding Adults Board Achievements

The Havering SAB organised a development day in June 2018 to review progress to date on implementing MSP locally.

What we think we have achieved so far	What we need to do next
There is a strong SAB focus on MSP including Development Day, safeguarding week and safeguarding conference.	Supporting a further cultural shift in terms of strategic thinking and operational activity, being clear what the Board can do to drive this focus.
	Board to consider how we can incorporate the work we are doing locally around MSP to fit with the tri-borough priorities of NELFT and MPS to avoid duplication of work.
Robust challenge takes place across the partnership but what difference are we actually making.	How can we evidence that what we do through the Board impacts on outcomes?
	How do we know the training impacts how people work/ organisational change.
	Police mentioned the board should consider services to share tri-borough. Challenge is working tri-borough with agencies to ensure a consistent message. Recognising differences across boroughs but also what we can share.
Safeguarding Board giving agencies and voluntary organisations the confidence to own their roles and powers.	Importance of empowering agencies to take the lead with safeguarding and breaking down boundaries, not always referring on.
	Agencies need to retain ownership of safeguarding matters even when seeking advice from ASC.
Good engagement SAB led on MSP i.e. attendance, working groups and Board work and members are effective. Challenge comes around how do we know what we are doing is making a difference? Providers forum, consider utilising this to push SAB messages. Consider more involvement from housing providers.	Agencies should consider how they engage with the wider community, how they build on established relationships with residents and handle low level risk without handing over to ASC as safeguarding is everybody's concern.

The results of this stock take provided us with a review of how well we are doing and identified some of the next steps in getting MSP right in Havering.

Safeguarding Update from Havering Adult Social Care

How service relates to safeguarding adults

Safeguarding is everyone's responsibility and all staff within Adult Social Care have a duty of care to ensure that adults at risk are safe from harm. ASC work together with partners to prevent and reduce both the risks and experience of abuse or neglect. ASC operates a specialist Safeguarding Adults Team that is a part of the Integrated Multi Agency Safeguarding Hub (MASH).

The Safeguarding Adults Team (SAT) supports effective decision making to ensure section 42 safeguarding enquiries are progressed appropriately. SAT provides a central referral point for all Safeguarding Adults concerns. The team undertake an initial screening, checking with other agencies for any useful information and advice that may be relevant to the case, and then decide whether a concern should progress to an enquiry under the London Multi-agency Policy and Procedures.

Following this referrals are made to the appropriate community team to progress the safeguarding enquiry. There are strong links with the community teams across ASC as section 42 enquiries remain their responsibility, but the SAT have a level of expertise which provide confidence and support to all practitioners involved in safeguarding matters.

The Safeguarding Adults Team also delegate lead responsibility for safeguarding enquiries to other appropriate partners (with professional support) which has more regular links with the adult at risk.

The SAT also refer cases to the Safeguarding Adults Board for consideration under the Safeguarding Adults Review (SAR) procedure.

In addition the SAT provides a development and expertise role by providing strategic and operational advice across the partnership; keeping up to date and developing new policy, procedures and guidance required to support the multi-agency safeguarding protocol and process; and support & promote the development of practice across the partnership.

The SAT acts as the Supervisory Body in respect of Deprivation of Liberty Safeguards and is responsible for considering the applications, commissioning the assessments and authorising the deprivation.

Adult Social Care also has its Quality Team, based in the Joint Commissioning Unit. This team is responsible for monitoring issues with care providers, including undertaking site visits, supporting with the development of action plans where issues have been

identified, and supporting ASC and commissioners in their direct work with care providers.

Activity during 2018/19 to advance organisational safeguarding priorities

ASC is a key member of the Safeguarding Adult Board (SAB) and fully participates in the work of the Board's workstreams, such as the Operational Boards that are linked to embedding new practice and learning from SARs and national changes to policy.

Over the past year, the Service has continued to move to working more closely with our partners including the Quality Team, CCG, BHRUT and NELFT to contribute to multi-agency safeguarding practice and partnership working arrangements, including joint quality and safeguarding visits to providers and an increase in professionals meetings for complex cases.

The SAT has redesigned a post to ensure that there is greater capacity to review and measure the outcomes of s42 enquires to establish whether the desired outcomes specified by the individual involve in the s42 process are being met.

There continues to be a notable increase in s42 referrals and DOLS work, including S21 objections, and the service is monitoring these to ensure that there ae sufficient resources available to cope with both the level of demand and the complexity of issues in the future.

ASC is a key member of, and works proactively with, the Multi Agency Risk Assessment Conferences for community issues and domestic violence. The MARAC allows partners to share information on high risk cases and discuss options for increasing the safety of the individuals concerned. The number of referrals to these MARACs from frontline social care teams has increased in year.

In order to support staff with their responsibilities around the Mental Capacity Act and capacity assessments there is a variety of training opportunities available includes mandatory MCA and DOLS and Safeguarding Training and Risk Assessment Training. The approach to risk assessment has also been reviewed and there is new tool in place to support assessment process, including care and support planning, reviews and carer's assessments.

The service is also progressing towards a strength base approach to practice (Better Living) placing vulnerability over 'eligibility for services'. This approach recognises that people and families are the experts in their own lives, so as social workers we need to listen to them and use the resources and skills available to build on their strengths, and to connect them to the right people, communities and organisations to make their lives work better. This will also lead us to work intensively with people in crisis help them regain stability and control in their life.

ASC is also in preparation for to roll out of a new client database (Liquid Logic) to offer staff better functionality and to better support multi-agency working, particularly with partners in health and also with care providers.

Havering Safeguarding Week 1-5 October 2018 was an opportunity to raise awareness in relation to how we identify and respond to the risks and concerns affecting the most vulnerable residents. This supported ASC staff to focus on important issues as new priorities arise and our population changes. The theme was is Managing Risk Together looking at some of the areas where we were particularly challenged domestic violence and modern slavery. It was also an opportunity explore how we assess the level of risk within our roles, how we communicate risk across agencies and how these decisions impact upon the outcomes vulnerable adults.

With partners, ASC also carried out joint learning events with partners linked to SARs to help understand what shared learning themes and challenges emerged from SARs and DHRs; how the learning themes help us understand what goes wrong; and establish what changes are required in order to reduce the likelihood of recurrence.

Utilising the views of adults who have experienced the process to improve services

'Making Safeguarding Personal' (MSP) runs throughout the ASC safeguarding process. MSP has a strong focus on outcomes and providing the support an adult needs to achieve their individual outcomes and to remain safe.

MSP outcomes focus has been strengthened throughout the safeguarding enquiry form, which has a requirement for staff to evidence the voice of the adult at every stage of the Safeguarding process. This is further monitored via our database where the specific desired outcomes of adult at risk are recorded. Performance can be measured as to whether the individual desired outcomes have been achieved

ASC create agreed action plans as a part of safeguarding enquires with the individual/representative. These are reviewed and subsequently follow-up calls can be made with the individually to establish whether the actions have been implemented.

The SAT, as part of its Quality Assurance process, also looks for feedback from the adult at risk or their representative at the conclusion of enquiries. Feedback forms are used to receive the views of individuals directly involved in the process. The comments and recommendations received enables feedback to the SAB Board, and also allows the service to reopen safeguarding if feedback indicates that individuals are not happy with the outcomes achieved. This is beneficial not only for the individual involved in the process but also for the staff working through the safeguarding enquiry and allows continued professional development in relation to the management of s42 enquires. As a direct result of the feedback gathered, the SAT are developing a leaflet to outline the responsibilities of Safeguarding as individuals identified that they found this confusing.

Furthermore, where individuals have difficulty being involved in safeguarding processes and decisions, and there is no one suitable to support them, advocacy is enabled. Advocates in social care are independent and are trained to help individuals understand their rights, express their views and wishes, and help make sure that their voices are heard.

Safeguarding Update from Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCG)

NHS
Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

How service relates to safeguarding adults

The CCGs have continued to maintain a high focus on Adult Safeguarding work within the borough of Havering. The Designated Nurse for Adult Safeguarding is the key member of the local safeguarding workforce and oversees the health system as a whole to ensure that it is working effectively to safeguarding adults at risk of abuse or neglect.

BHR CCGs have a responsibility to ensure that organisations that they commission have effective safeguarding arrangements in place and that the Government approved safeguarding principles are applied in terms of how we operate as an organisation and when working with our partners.

In addition the CCGs have continued to meet its statutory requirements for adult safeguarding as outlined in the Care Act (2014).

Activity during 2018/19 to advance organisational safeguarding priorities

Throughout 2018/19, the CCGs have continued to contribute to multi-agency safeguarding practice and partnership working arrangements. This has included attendance at all Safeguarding Adult Board (SAB) meetings and participation in the work of the SAB Committees work streams.

The CCGs have worked closely with Local Authority colleagues in conducting quality assurance and safeguarding visits to care homes with nursing providers. The CCGs have updated its 'Care Home with Nursing Strategy' for 2019-2022. This strategy sets out the vision for an agreed approach to commission continuous improvements and compliance in the quality of care home services. The Designated Nurse for Adult Safeguarding chairs the Local Quality Surveillance Group which is the forum where the CCGs, CQC and Local Authority quality leads share information relating to concerns about providers and to review assurance visit findings for homes which have not had recent inspections by the CQC.

The Designated Nurse for Adult Safeguarding has continued to ensure that the CCGs have continued to fulfil requirements from all statutory guidance and has maintained a focus on safeguarding development and training with an emphasis and focus on the domestic violence, adult neglect and mental capacity assessment and deprivation of liberty safeguards statutory requirements.

The CCGs' 'Mental Capacity Act and Deprivation of Liberty Safeguards Policy' was approved at the Quality and Safety Committee on 12 February 2019. This policy is now available on the BHR CCG website and the GP CCG websites across Havering. Training has been rolled out to the Continuing Healthcare Team Nurses in March 2019 to raise awareness of implementation of the Policy and to support practitioner knowledge of the application of the MCA and DoLS framework.

The Designated Nurse for Adult Safeguarding attends the Prevent Strategic Group and Counter Terrorist Local Profile updates. Attendance ensures CCG compliance with legislative duties for the Counter Terrorism Act 2015 and the opportunity to further monitor what health providers are delivering to support Counter Terrorism/Prevent requirements.

The London Modern Slavery (LMSL) Group has been set up primarily for those representing or leading work efforts within their Local Authority to tackle Modern Slavery and Human Trafficking and support survivors. The Designated Nurse for Adult Safeguarding joined this group on 31 January 2019 and will continue to support this agenda on behalf of the CCGs.

The CCGs have also delivered the Local Area Contract (LAC) provision for the National Learning Disability Mortality Review (LeDeR) Programme. The Designated Nurse for Adult Safeguarding is the Local Area Contact for Havering and attends the local LeDeR Steering Group which meets bi-monthly.

Utilising the views of adults who have experienced the process to improve services

The Designated Nurse for Adult Safeguarding attendance Local Authority Section 42 meetings, some of which include service user representation. Views of service users provide valuable feedback for agencies involved and enables exploration of their desired outcomes from the enquiries.

The Designated Nurse for Adult Safeguarding attends Quality Assurance visits at Care Homes with Nursing alongside the Local Authority Safeguarding Teams, which involves speaking to adults and service users and seeking their views.

Safeguarding Update from Metropolitan Police East Area Basic Command Unit

Activity during 2018/19 to advance organisational safeguarding priorities

Introduction of a dedicated Risk Reduction team, which consists of MARAC, Clare's Law Disclosure Officer, Domestic Violence Prevention Order Officer and a DV proactive

element. The aim of this team is to reduce repeat victims by providing additional support through DVPN enforcement. East Area Safeguarding team have obtained the highest volume of DVPN/O and Clare's Law disclosures (RTK) in the Metropolitan Police Service area.

Mental Health Officer is now based in MASH to commence multi-agency problem solving approach to those adults who are repeat contacts through poor mental health.

The Metropolitan Police Service has increased training access. A specific Missing Persons Course for Inspectors has been developed.

Utilising the views of adults who have experienced the process to improve services

Officers from our Safeguarding Investigative Teams have taken part in 'Voice of the Survivor' workshop where we had the opportunity to listen to DV survivors and understand the impact of officer behaviours on their confidence.

Safeguarding Update from North East London NHS Foundation Trust (NELFT)

NELFT NHS
NHS Foundation Trust

How service relates to safeguarding adults

Provider of physical and mental health services, with an operational and strategic responsibility for safeguarding all vulnerable service users.

Activity during 2018/19 to advance organisational safeguarding priorities

Joint multi-agency safeguarding training through the SAB. Participation in SARs and sharing the learning across the organisation. Participation in the Safeguarding Week to promote safeguarding with partner agencies.

The Safeguarding Standard Operation Procedures (SOP) have been reviewed to reflect the 'Think Family' ethos. The updated safeguarding intranet page was relaunched in 2018. This provides a clear, user-friendly page enabling staff to source local information more efficiently.

Improvements include embedding tools such as child sexual exploitation (CSE), female genital mutilation (CGM) and Safe Lives DASH Risk Assessment checklist (DV). This has been strengthened within safeguarding training, safeguarding supervisor's networks and link practitioner forums.

The bi-annual adult safeguarding link practitioner's forums were well received by

attendees. The event focused on domestic abuse, managing homelessness and Modern Slavery.

The Safeguarding Team has worked with HR and reviewed the 'Managing Safeguarding Allegations against Staff' policy.

Utilising the views of adults who have experienced the process to improve services

NELFT utilises all views and learning from incidents to inform training across the organisation.

The NELFT Safeguarding Team completed a range of audits in 2018/19. Good practice identified included timeliness and quality of advice given by the Safeguarding Team, 100% compliance in gaining consent within the Making Safeguarding Personal objectives, and an increase in the appropriate use of raising safeguarding concerns to the Local Authority.

Safeguarding Update from Barking & Dagenham, Havering and Redbridge University Hospitals NHS Trust (BHRUT)

NHS
Barking, Havering and Redbridge
University Hospitals
NHS Trust

Activity during 2018/19 to advance organisational safeguarding priorities

BHRUT have continued to develop Safeguarding Adults Practice by responding to learning adult concerns and/or Safeguarding Adult Reviews.

Areas developed during 2018/19 have included updating the Trust's Safeguarding Adult Concern form to prompt referral to the London Fire Brigade if self-neglect or hoarding has been recognised.

The Mental Capacity Assessment form has been simplified to aid completion and monthly workshops which use innovative training videos (role play) to assist staff in the practical application of Mental Capacity Assessment have been created. A Mental Capacity Act newsletter is produced quarterly to provide accessible information to all Trust staff.

A patient information leaflet has been developed to support service users to understand the adult safeguarding process and to encourage Making Safeguarding Personal.

Utilising the views of adults who have experienced the process to improve services

The Acute Hospital Trust is involved at the start of the safeguarding process. The desired outcome of the service user is captured when the safeguarding concern is raised; whether the desired outcomes are met is recorded at the end of the process by the Local Authority.

Safeguarding Update from Havering Housing Services

How service relates to safeguarding adults

We provide:

- Advice and/or accommodation for vulnerable homeless individuals and families.
- Direct housing management services to 9,400 general needs properties, 1100 properties and 26 Houses in Multiple Occupation allocated to homeless families via the Private Sector Leasing Project and 3 Hostels.
- An officer dedicated to dealing with the support needs and prevention of Street Homelessness.
- Specialist Sheltered Housing for older people.
- Telecare services 24/7, 365 days per year to vulnerable clients residing within the borough.
- We produce support plans for our vulnerable tenants and for all young adults leaving care housing within our stock.

Our Tenancy Sustainment Service seeks to prevent evictions and sustain tenancies wherever possible. This is particularly pertinent in our response to the Welfare Reforms and the transition of tenants from Housing Benefit to Universal Credit. This has seen an increase in rent arrears but not corresponding increase in evictions.

Sheltered Housing-related support to encourage elderly vulnerable residents to remain well, healthy and living as independently as possible for as long as possible.

Activity during 2018/19 to advance organisational safeguarding priorities

Our work on sustaining tenancies has prevailed throughout 2018-19. We have visited all our residents living alone who are over the age of 85 and have completed support plans to assist in the continuity of their wellbeing.

We have via a pre-eviction panel scrutinised every possible eviction and sought final

remedies for families in crisis. We have participated in all Partnership forums and LS Boards to ensure that strategic direction is maintained. Staff have been encouraged and have attended a range of safeguarding training and events throughout the year.

The Sheltered team attend regular safeguarding training as and when available. Team staff also attend sessions during Safeguarding Week, which always has something to offer all members. We hold regular monthly team meetings and safeguarding is a usual topic of conversation with colleagues sharing experiences, knowledge, incidents and referrals. Team members attended the Serious Case Review sessions held during 2018 to aid learning and experience. Sheltered have set up a Sheltered Team Safeguarding Working Group which will meet quarterly during 2019 onwards, the aim being to share experiences and outcomes to promote learning and best practice within our service.

Utilising the views of adults who have experienced the process to improve services

We have a specific post that is attached to the Multi-agency Safeguarding Hub so that immediate feedback can be provided to staff on cases or instances of safeguarding that have common themes.

We have sought to learn where possible from the Safeguarding Adult Review process. We also seek to learn from our own complaints process which include instances that are safeguarding related.

The outcomes and experiences of our service users referred under safeguarding are discussed confidentially within the team. Our resident views around the process and the outcome informs team members on the positives and negatives of referrals and the experiences of all involved form the basis of any new referrals as we learn so much for each individual case.

Safeguarding Update from Healthwatch Havering

healthwatch Havering

How service relates to safeguarding adults

Consumer watchdog for Health and Social Care.

Activity during 2018/19 to advance organisational safeguarding priorities

Updated adult safeguarding procedures. Appointed Speak Up Guardian.

Utilising the views of adults who have experienced the process to improve services

Views of adults shared with London Borough of Havering.

Safeguarding Update from the London Ambulance Service

London Ambulance Service NHS Trust

What we did

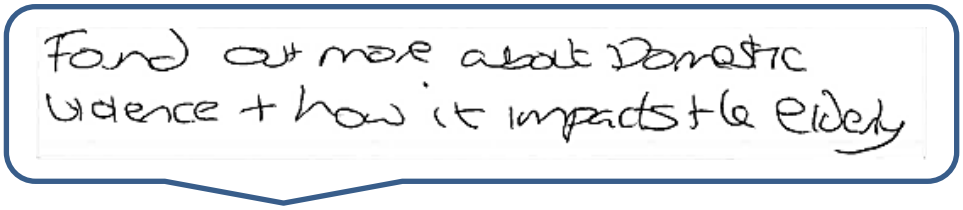
- Secured funding to increase safeguarding team by 100% to enable a dedicated safeguarding specialist in each area of the Trust.
- 7% increase in safeguarding concerns and referrals.
- Introduced 24/7 safeguarding telephone line for staff.
- >90% safeguarding training compliance.
- Introduced Quarterly Safeguarding Newsletter.
- Produced new safeguarding pocketbook for staff.
- Introduced Chaperon and Supervision policies.
- Held Safeguarding Conference for over 170 staff and partners.
- Introduce Learning Disability and Mental Capacity Act Strategies.

Havering Safeguarding Week 2018

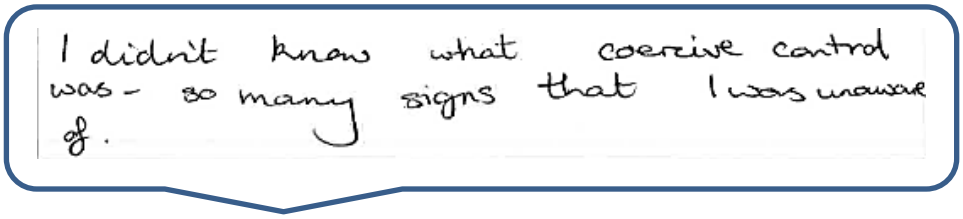
Havering Safeguarding Week 2018 ran from 1 – 5 October, beginning with the annual Safeguarding Conference and continuing with throughout the week with learning events and briefings delivered to staff from across the local multi-agency partnership on a wide range of current and emerging issues around adult safeguarding.

Below are some comments received on evaluation forms following individual learning events and briefings.

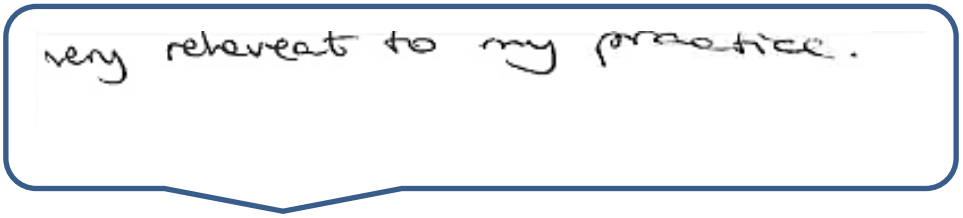
Comment from a Social Worker following an event on Elderly Abuse, delivered by Havering Women's Aid:



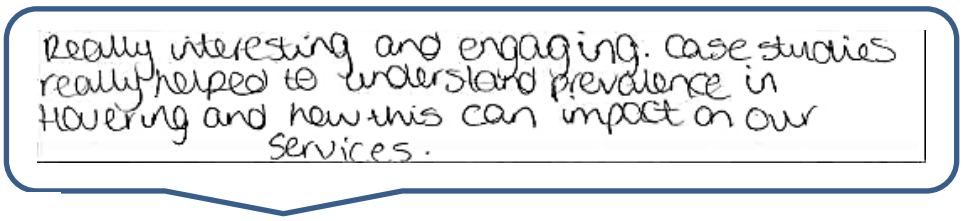
Comment from a member of staff in Havering's Early Help Service following an event on Coercive and Controlling Behaviour, delivered by the Met Police:



Comment from a Health Visitor following an event on Domestic Violence, delivered by Havering Women's Aid:



Comment from a Safeguarding Adviser at BHRUT following an event on Human Trafficking and Modern Slavery, delivered by the Met Police:



Safeguarding Priorities for 2019-2023

Agency Identifying Priorities	Identified Priorities
Havering Adult Social Care	• Formally launch 'Better Living' (February 2020) • Develop integrated service offer with Primary Care Networks, NELFT and other partners. • Introduce Local Area Coordination (initially to Harold Hill followed by Rainham) to increase community resilience, with safeguarding central to the model. • Work with Children's Safeguarding and wider council partners to develop and embed a robust approach to Transitional Safeguarding • Embed social care and council response to Domestic Violence and Modern Slavery. • Work with Housing and external partners in reducing and preventing homelessness. • Continued working with social care providers to ensure a stable and robust provider market, delivering quality outcomes for residents
BHR CCGs	• Domestic Violence • Homelessness • Sexual Exploitation • Modern Slavery • Self-neglect
Metropolitan Police East Area Basic Command Unit	• Residents will have improved health and wellbeing, with less health inequalities between EA BCU residents and the rest of London: No one will be left behind. • Increased resilience empowered to not just survive, but to thrive. • Residents will benefit from a place-based system of care, where partners across the EA BCU system work together • To get upstream of care and improve the health of the population. • Partners will increasingly focus on outcomes and impact, with outcomes-based commissioning working effectively to improve outcomes for residents. • Early Diagnosis and Intervention: Our residents will be empowered to recognise symptoms, act on them and manage their long-term conditions, through an increased focus on early diagnosis and intervention. • Building individual and community strength: Our residents will be empowered to not survive in the face of adversity, but to thrive across the life-course.

NELFT	• Place-based Care Model • Self-Care • Access to Community Support
Havering Housing Services	• To combat homelessness and overcrowding by increasing the stock of housing via a major regeneration programme. • To further invest in Support Planning to enhance preventative measures and early intervention.
Healthwatch Havering	• Sexual abuse: PCN's need to ensure that there is a local counselling service available – not an on-line service – 1 in 4 individuals experience sexual abuse at some time in their lives. • Carers: develop a partnership with BHRUT and NELFT which supports carers – ensuring that not just the patient is ready for discharge – emotional blackmail is unacceptable. And is in itself abuse.
London Ambulance Service	• Secure sufficient resources to develop safeguarding in the Trust. • Monitor Trust's safeguarding processes and compliance. • Support Trust with safeguarding practices and requirements. • Assure Trust processes by driving consistency and improvements in safeguarding practice. • Forge effective relationships internally and externally. • To be outstanding in quality standards and drive continual improvements. • Excellent Governance and Assurance of Trust's safeguarding processes and compliance. • Development of the Safeguarding Team. • Successful delivery of safeguarding training plan, local education and supervision. • Safeguarding innovation and review current practices to identify cost savings. • Ensure integration of 111 and IUC. • Forge effective relationships internally and externally to safeguarding adults.