



Annual Report

April 2019 –

March 2020



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Introduction by Havering SAB Independent Chair, Brian Boxall



The Havering Safeguarding Adults Board (HSAB) has again had a busy 2019/20. This annual report aims to provide an overview to the work of the Board and individual partners.

The year saw the completion of one Safeguarding Adult Review (SAR) SW, and the commissioning of a second CW. A SAR is undertaken in response to a tragic event and I would like to extend my condolences to the families linked to these reviews and thank them for their invaluable input. The learning outcomes from the reviews are set out in this report and the SAB will continue to use these outcomes to challenge agencies to improve responses to vulnerable adults.

2019/20 saw the HSAB progress its plan to work more collaboratively with our neighbours in Barking & Dagenham and Redbridge. This included the holding of a joint multi agency seminar to sharing the learning from our reviews across the tri-borough. This enabled us to learn from each other. Agency feedback to this seminar is evidenced in this annual report.

In 2019 we held our second joint adult and children annual Safeguarding Week. This was once again well received with excellent attendances at the numerous seminars held during the week. The annual conference focused on the theme of all aspects of exploitation and was fully subscribed.

The HSAB's major commitment this year was to participate in Alcohol Change UK's national, multi-partner project to develop guidance and training on responding to vulnerable adults who are chronic and change-resistant dependent drinkers. This project will continue into 2020/21.

Whilst the HSAB had commenced the development of a work plan for the year 2020/21 its focus has been impacted upon by outbreak of COVID 19 virus.

This unprecedented event has had a significant unforeseen impact on all our lives in both work and personal and has required an immediate response to safeguarding. This has posed major challenges for all agencies and the community. The HSAB during 2020/21 will work closely with the board partners to identify the risks posed by COVID 19 and look to help agencies work with and support each other.

Despite the additional pressure, the HSAB will during 2020/21 continue to undertake SARs when required. It will also look to hold the 2020 Safeguarding Week online in November.

I would like to thank all the partners and their staff for the commitment they have demonstrated during 2019/20 to the HSAB and its work. 2020/21 will place all staff and agencies under tremendous pressure and I would like to thank everyone in advance for your continued commitment to safeguarding the most vulnerable in Havering.

A handwritten signature in black ink, appearing to read 'B Boxall'.

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

professional 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

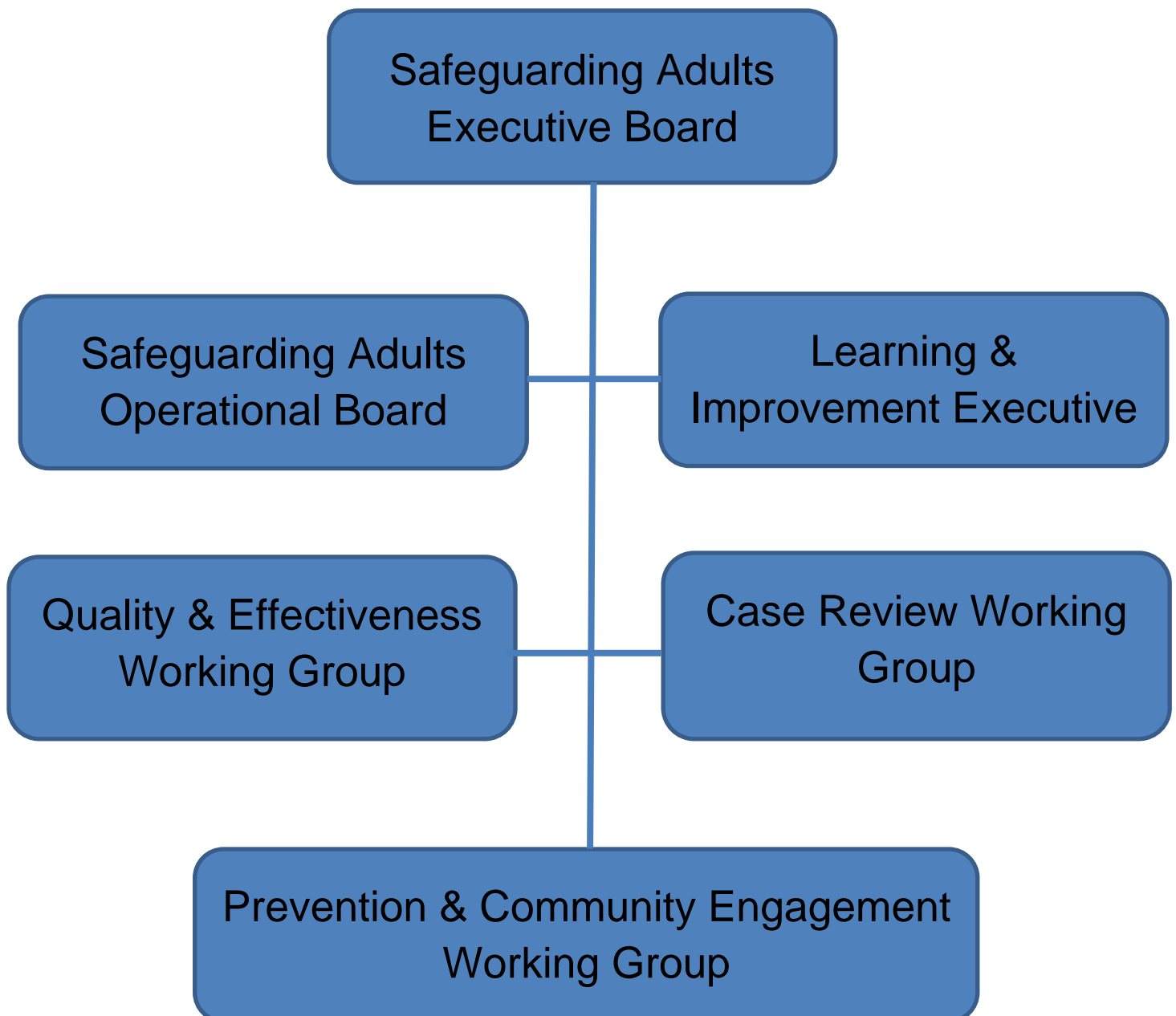
As directed in *The Care Act 2014* (section 43, schedule 2), a Safeguarding Adults Board must publish an annual report on:

- 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 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, 21% ASB crime occurs in Romford town centre

Population, 2019 - 2023

Age	2019	2023	% Change
0-17	58361	63085	8.1 %
18-64	154482	163262	5.7 %
65+	46709	50298	7.7 %
All Ages	259552	276645	6.6 %



14.9% one person households aged 65+



259,552 residents

A borough with a growing population - the oldest in London



46,709 over 65s

The Borough holds the oldest population in London with the median age of 40 years



48% Male



52% Female



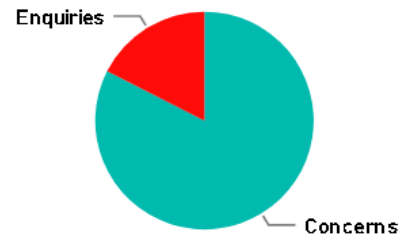
16.3% BAME

The Borough's BAME population is expect to increase to over 20% by 2027



Concerns & Enquiries

The number of safeguarding concerns received in 2019-20 increased by 6.4% from 4706 in 2018-19 to 5007 in 2019-20. Whilst there was a minimal increase to 1062 enquiries in 2019-20 compared to 2018-19.



Gender

Individuals involved in a safeguarding concern

45% Male

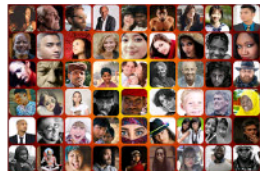


55% Female



Ethnicity

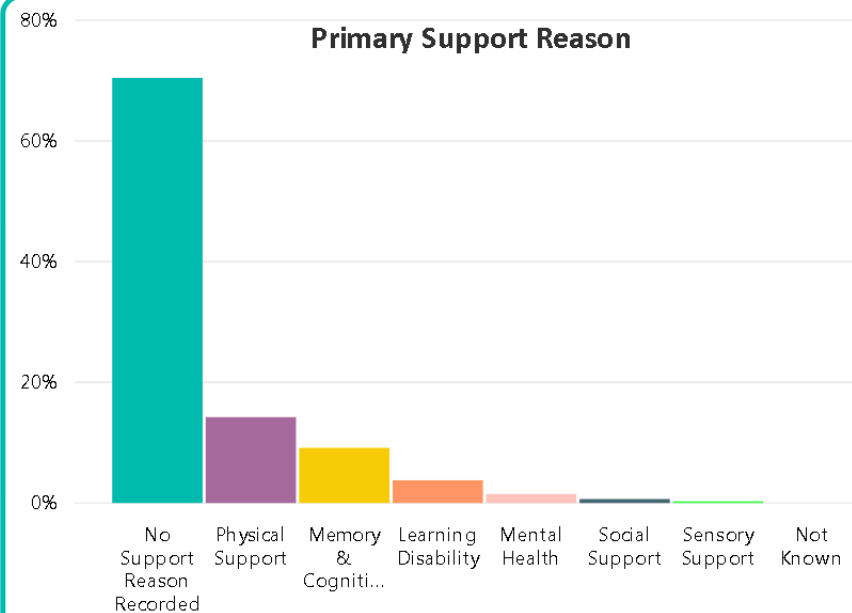
65.2% of individuals involved in a safeguarding concern were white



6.7% of individuals involved in a safeguarding concern were Black Asian or Other minority groups

28% of individuals involved in a safeguarding concern did not declare their ethnicity

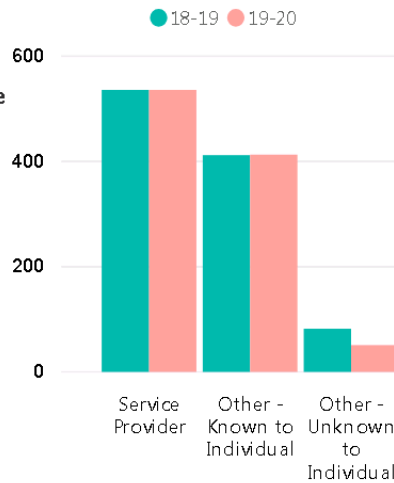
Primary Support Reason



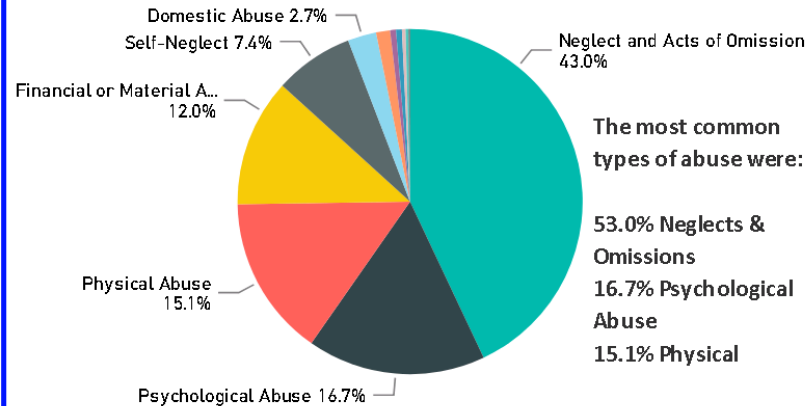


Source of Abuse

The number of concluded enquiries in 2019-20, where the source was Other - Unknown, reduced by 37.8% in comparison to 2018-19. Where the source of abuse was the Service Provider & Other - Known, these remained the same compared to the previous year.



Type of Abuse



The most common types of abuse were:

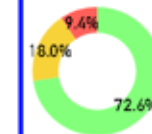
53.0% Neglects & Omissions
16.7% Psychological Abuse
15.1% Physical

Location of Abuse



The highest proportion, 48.3%, of location where abuse took place was in a person's own home. This was followed by 29.3% in a Residential Care Home setting.

Risk

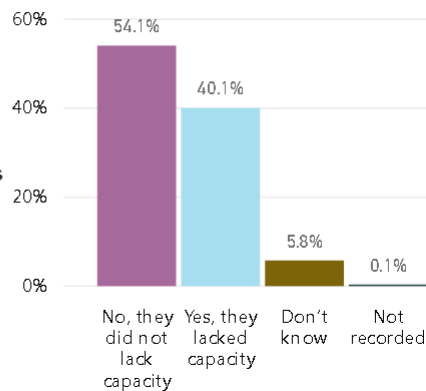


In cases where action was taken 90.6% of risks were reduced or removed

N.B. The statutory definition of Neglect and Acts of Omission includes 'ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of necessities of life such as medication, adequate nutrition and heating'.

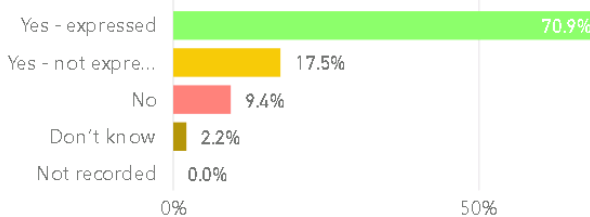
Mental Capacity

The percentage of completed enquiries where the adult at risk had an assessment of their Mental Capacity was 94.2%, with 40.1% receiving an outcome of lacking capacity



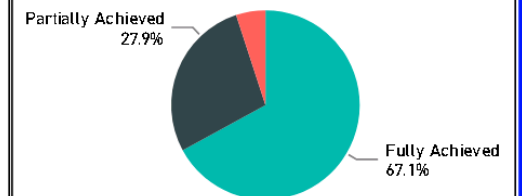
Making Safeguarding Personal

% MSP Asked



88.4% of adults at risk or their representative were asked about their desired outcomes.

% MSP Achieved



95% of desired outcomes were either Fully or Partially achieved

Safeguarding Adults Reviews

During 2019/20, the Havering SAB actively progressed one Safeguarding Adults Review (SARs), into the death of SW.

Towards the end of 2019, the Havering SAB commissioned a further SAR, into the death of CW, which will be progressed during 2020/21.

The death of SW

SW died in May 2017, at the age of 56, three weeks after relocating from Havering to a property in Essex. She had several diagnosed mental health difficulties and had been receiving services from North East London NHS Foundation Trust (NELFT) since moving to Havering in 2010. The inquest into her death concluded that SW killed herself and that her death was due to suspension by ligature and multiple drug toxicity.

The review into SW's death was conducted by independent reviewer, Alastair Kidd; chaired by London Borough of Havering's Director of Adult Services, Barbara Nicholls; and received contributions from the following agencies:

- North East London NHS Foundation Trust (NELFT);
- London Borough of Havering (LBH) Housing Services;
- Essex Partnership University NHS Foundation Trust (EPUT);
- Barking & Dagenham, Havering and Redbridge University Hospitals NHS Trust (BHRUT);
- Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs);
- London Ambulance Service (LAS); and
- Peabody (formerly Family Mosaic).

The independent reviewer met with members of SW's family to seek their views and enable them also to contribute to the SAR.

Key features of the case identified during the review included:

- professional interventions in relation to SW's complex mental health needs;
- the absence of a safeguarding referral to Adult Social Care;
- the response by LBH Housing Services to her homelessness application;
- their eventual out-of-borough relocation of SW to the property in Essex; and
- the impact of this on the continuity of care she received from health services.

The SAR resulted in an extensive range of recommendations, which have been accepted by the Havering SAB, and also the Essex SAB where relevant. Planning is currently underway to implement the learning from SW's case across the multi-agency safeguarding partnership in Havering.

The death of CW

CW died in July 2019, at the age of 61, while admitted to Queen's Hospital after suffering a stroke, one of several hospital admissions in the weeks preceding his death. These hospital admissions had followed a period of instability for CW in relation to his housing.

The Havering SAB has commissioned the Social Care Institute for Excellence (SCIE) to undertake a SAR using their Learning Together methodology, with preliminary research questions focusing on the following issues:

- assessment and placement by LBH Housing Services of adults with physical and mental health needs who may struggle to maintain their personal care and are facing imminent homelessness;
- agencies working together to support a vulnerable adult, notice their deterioration and respond appropriately;
- hospital discharge planning, including delivery and effectiveness of re-ablement support;
- role of the GP as a central point for information and planning.

The SAR will commence during 2019/20.



Havering Safeguarding Adults Board achievements

Havering Safeguarding Week 2019

Havering Safeguarding Week 2019 ran from 11th – 15th November, 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.

This year's Safeguarding Conference focused on the theme of exploitation and explored key forms of exploitative abuse affecting vulnerable adults, including: sexual exploitation, criminal exploitation through mechanisms such as county lines and cuckooing; and personal fraud and scams. The conference presented these different issues from a range of organisational perspectives and highlighted how agencies across the local multi-agency safeguarding partnership can improve outcomes by working collaboratively across services.

Learning events throughout the rest of Safeguarding Week, attended by practitioners from a range of agencies across the partnership, included the following topics:

- Unconscious Bias and Diversity Law;
- Homelessness and Modern Slavery;
- Universal Credit: It Does Affect Your Working-Aged Individuals and Families;
- Stopping Over-Medication of People With a Learning Disability;
- Systemic Practice Overview;
- Safeguarding for Housing Contractors;
- Mental Capacity Act and Deprivation of Liberty Safeguards;
- Dementia Awareness;
- Adult Mental Health First Aid;
- LGBT+ Workshop: Improving Awareness and Understanding;
- Prevent and Hate Crime;
- Elderly Abuse;
- LGBT+ and Domestic Violence;
- Understanding Rough Sleepers and the Barriers;
- Male Victims of Domestic Violence;
- Liberty Protection Safeguards Workshop;
- Challenging Conversations;
- Open Dialogue: A Model for Mental Health Care in Adults;
- Suicide Prevention: A Brief Overview;
- Coercive and Controlling Behaviour; and
- The Role of the Independent Domestic Violence Advocate.

Tri-borough SAR Learning Event

On 26th November 2019, the Havering SAB collaborated with the Safeguardings Adults Boards in its neighbouring boroughs of Barking & Dagenham and Redbridge to produce a half-day learning event held at Barking Learning Centre to explore themes emerging from SARs conducted across the BHR (Barking & Dagenham, Havering and Redbridge) footprint and potential tri-borough responses.

Professor Michael Preston-Shoot, who conducted the SAR on the death of Ms A for the Havering SAB in 2017, delivered a presentation to the BHR learning event on the themes emerging from SARs nationally, which enabled participants to situate the identified local issues within a broader context and explore wider collaborative means to address them.

Evaluations on the BHR learning event completed afterwards by participants included the following feedback:

From a Metropolitan Police Mental Health Team SIM (Serenity Integrated Mentoring) Officer:

Learning and Impact	
What have you learnt from this event?	HAVE A BETTER UNDERSTANDING OF OTHER PROCESSES
Please detail three actions that you will undertake as a result of today that will impact on safeguarding adults?	1. PUSH FOR SIM TO BE IMPLEMENTED 2. CONTINUE TO MENTOR THOSE ENGAGING 3. CONTINUE TO BUILD GOOD WORKING RELATIONSHIPS TO CONTINUE IN MY ROLE

From a Police Officer within the Havering MASH:

Learning and Impact	
What have you learnt from this event?	LEARNING ABOUT OTHER AGENCIES PROCESSES.
Please detail three actions that you will undertake as a result of today that will impact on safeguarding adults?	1. READ POLICE REPORTS MORE THOROUGHLY 2. THINK OF THE BIGGER PICTURE. 3. LIAISE FURTHER WITH OTHER AGENCIES FOR ADVICE.

From a senior leader at Havering Adult Services

Learning and Impact	
What have you learnt from this event?	Partnership working. Making Learning Real - Real Stories.
Please detail three actions that you will undertake as a result of today that will impact on safeguarding adults?	1. Share Learning from today. 2. Support Org & Practitioners event. 3. Work on having more tri Boroughs Goals.

From a Senior Leader at the local NHS CCGs (Clinical Commissioning Groups)

Learning and Impact	
What have you learnt from this event?	ISSUES THAT CROSS THE WHOLE RMR SYSTEM.
Please detail three actions that you will undertake as a result of today that will impact on safeguarding adults?	1. CONSIDERATION OF STRENGTHENING SUPERVISION. 2. SHARE DETAIL OF SESSION WITH COLLEAGUES. 3.

From a Senior Probation Officer:

Programme Content	
What is your opinion of the Programme content?	Well informed. Great to have a good cross section of Reps from all boroughs
What parts were particularly useful?	Michael's presentation - beginning a good exercise
What parts were not useful?	None

From a Safeguarding Lead at the local NHS Hospital Trust

Please detail three actions that you will undertake as a result of today that will impact on safeguarding adults?	1. Promote Mental Capacity Act 2. Review for exercise as self neglect 3. Build Relationships with LFB
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Participation in Alcohol Change UK's Safeguarding Vulnerable Dependent Drinkers Project

In January 2020, the Havering SAB committed to participate in Alcohol Change UK's national, multi-partner project to develop guidance and training on responding to vulnerable adults who are chronic and change-resistant dependent drinkers.



Seeking as many SABs as possible to participate in this initiative, Alcohol Change UK are aiming to improve local practice as well as challenging and informing central government about challenges required at a national level.

Alcohol Change UK is working in partnership on the project with Professor Michael Preston-Shoot and it will be led by Mike Ward, who heads up their Blue Light project on complex drinkers, which has recently won both a Guardian Public Service Award and a Royal Society of Public Health Award.

The project will continue through 2021/21 and will be built around seven stages:

- Scoping the problem;
- Identifying good practice;
- Building a consensus on best practice;
- Developing and publishing national guidance;
- Making recommendations for change;
- Developing a training course; and
- Providing local training and presentations.



Safeguarding Update from Havering SAB Member Agencies

Safeguarding Update from Havering Adult Social Care



How this service relates to safeguarding adults

The central referral point for safeguarding concerns is the Safeguarding Adults Team (SAT), which operates within the Havering Multi Agency Safeguarding Hub (MASH). Being part of the MASH ensures that Adult Social Care (ASC) can work closely with key interagency partners and share essential information to prevent and reduce the risks and experience of abuse and neglect.

The SAT review and triage all safeguarding concerns and decide whether a concern should progress to an enquiry under the London Multi-agency Policy and Procedures. Following this, section 42 referrals are made to the appropriate community team to progress welfare checks or safeguarding enquiries. Whilst s42 enquiries are the responsibility of the community teams once allocated, the SAT are available to provide expertise and support to all practitioners involved in safeguarding matters. The SAT also delegate lead responsibility for safeguarding enquiries to other appropriate partners that have more regular links with adults at risk. The SAT can also refer 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 and 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 a Quality Team, based on 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.

ASC is a key partner in both the Community and Domestic Violence MARAC. At the MARAC, ASC provides support for partners involved in complex cases requiring a multi-disciplined/service approach.

Activity during 2019/20 to advance organisational safeguarding priorities

ASC have worked to strengthen understanding of Domestic Violence (DV) across the service to support practice. All procedures for domestic violence have been reviewed against the 2016 NICE Quality Standard (QS116). Significant training has been rolled out and will continue to be made available to practitioners and to providers.

In order to support staff with the responsibilities around the Mental Capacity Act and capacity assessments, there are a variety of training opportunities available, including mandatory MCA and DOLS and Safeguarding Training. The service has continued to strengthen Mental Capacity understanding and practice. Mental Capacity refresher training is mandatory and to be completed at least annually by all relevant ASC staff. The Mental Capacity and DOLS Policy, Procedure and Guidance have been reviewed and updated and circulated to all staff.

There has been a considerable focus around developing and supporting practice around assessing risk. The Risk Assessment policy and the approach to risk assessment has been reviewed and a new tool is in place to support the assessment process, including care and support planning, reviews and carer's assessments and on LAS. Mandatory risk assessment training was rolled out across the service to be completed by all staff, and compliance against this is monitored.

The service has been involved in the review of the Community MARAC Terms of Reference, specifically including clearer referral pathways and criteria, and to support clearer triggers for escalation of cases requiring multi-agency input and discussion. From the MARAC, multi-agency work has occurred around protection of vulnerable adults in the Havering community, in partnership with the Police and NELFT.

Work has also been focused around supporting staff to develop a greater understanding of mental health issues through further promotion of joint working and lessons learned. Applied Suicide Intervention Skills Training was made available to all staff. The Learning and Development Team attended 'Train the Trainer' Mental Health First Aid training to increase local capacity to deliver this training more frequently and, as a result, Mental Health First Aid training is now regularly available for staff.

The service has worked closely with internal partners to ensure positive safeguarding practices. ASC has worked closely with the Community Safety Teams to ensure that we have robust strategies around domestic violence. The Violence Against Women and Girls (VAWG) group was launched, and further work has gone into the terms of reference and representation at the Domestic Violence MARAC.

The service has also moved towards a strengths-based approach to practice (Better Living), which was formally launched in February 2020, placing vulnerability over 'eligibility for services'. This approach drives practitioners to work intensively with

people in crisis to help them regain stability and control in their life.

Activity undertaken to support the SAB in meetings its key objectives

ASC is a key member of the SAB and fully participates in the work of the SAB work-streams, such as the Operational Boards that are linked to interagency working and embedding new practice and learning from SARs and national changes to policy.

Interagency working is a key objective of the SAB. ASC has continued to develop positive working relationships with the CCG, BHRUT and NELFT to contribute to multi-agency safeguarding practice and partnership working arrangements, including joint safeguarding visits to providers and professionals meetings for complex cases.

A key focus for the SAB is to bring about positive outcomes for the vulnerable adults who live in Havering. ASC have worked with Housing, NELFT and voluntary groups on the SAB Prevention & Community Engagement Working Group around key themes such as homelessness and minimising exploitation of at-risk groups.

The SAB also has responsibilities around monitoring and reviewing progress in safeguarding practices. ASC is also a key partner of the SAB Quality & Effectiveness Working Group, where performance is regularly reviewed and “dip samples” of cases are carried out with an interagency focus. As a result of these dip samples, future themes for focus and audit are identified.

Obtaining the views of adults who have experienced the safeguarding process, and the extent to which they outcomes they wanted were realised

The ASC safeguarding process is built upon the principles of Making Safeguarding Personal (MSP), which has a strong focus on individuals’ desired outcomes. The individual is asked what they want as an outcome of the safeguarding process and the practitioner is then directly informed by these desired outcomes through the enquiry. The adult at risk is supported to achieve their individual outcomes whilst remaining safe. As a result, the voice of the adult at risk is central to the enquiry and the agreed action plan. The safeguarding enquiry form is designed to evidence the specific desired outcomes of an adult at risk throughout the process, and ASC are able to measure whether these desired outcomes have been achieved. As at February 2020 (last available statistical return), ASC had achieved a 97.5% recording rate for individual outcomes. Of the individuals whose outcomes were recorded, 95.6% were fully or partially achieved.

As part of the SAT quality assurance process, feedback forms are used to receive the views of individuals directly involved in the process, such as the adult at risk or their representative, at the conclusion of enquiries. The commends and recommendations

received enable feedback to the SAB Board, and also allows the service to reopen a safeguarding enquiry if feedback indicates that individuals are not happy with the outcomes achieved. This is beneficial not only to the individual involved in the process, but also to the staff working through the safeguarding enquiry, and allows continued professional development in relation to the management of s42 enquiries.

Obtaining the views of front-line practitioners about outcomes for adults and about their ability to work with them in a personalised way

Within the safeguarding enquiry report, there is an area for the practitioner to record whether the outcomes desired by the individual are achievable or safe to achieve. These are reviewed during audits, and feedback can be gathered from the practitioner regarding particular areas of concern. During audits, practitioners are directly asked how they felt the case went and what needs to be put in place in future to help them undertake their roles more effectively.

ASC has rolled out reflective supervision practice across the service and this will be developed further in 2020/21. This allows practitioners the opportunity to discuss any areas that are particularly challenging, including safeguarding, and key or frequent themes are fed back to service managers.

In addition, SAT has organised a number of information sessions at team meetings to cover key themes: managing risk; Mental Capacity; and managing safeguarding referrals and welfare concerns. They also use this opportunity to gather information and feedback to inform changes to practice or guidance. SAT also look at safeguarding cases and work with managers and seniors to investigate any issues around safeguarding cases, the impact of safeguarding on the teams, reviewing complex cases, considering why cases are not closed, and to consider capacity issues across the service.

Activity undertaken to promote the better reporting of adult abuse and neglect

ASC was a key partner involved in Havering Safeguarding Week 2019, which is an opportunity as a multi-agency safeguarding partnership proactively to promote the welfare of adults in Havering and across the Council and partners, and raise awareness of how to recognise and respond to indicators of abuse and neglect. 2019's Safeguarding Conference focused on exploitation, including: sexual exploitation; criminal exploitation through mechanisms such as county lines and cuckooing; and personal fraud and scams.

As part of Better Living, a framework has been developed for practitioner use to ensure that staff have access to a wider range of easily-accessible information in one place. The mechanisms for referral to SAT are included. In addition, the referral mechanisms to the MARACs are also made clear.

Work is also undertaken to ensure that all commissioned providers receive the appropriate level of training around safeguarding and making referrals, and this will also now include domestic abuse, so that they are able to recognise the risks and understand how to make appropriate referrals. The Quality Team and SAT also work closely with commissioned providers to ensure they are aware of their responsibilities around safeguarding and fully understand the referral mechanisms.

How we know that SAB training impacts on how people work and organisations change

Following all training, an evaluation form is completed. Specific questions on the form ask practitioners whether the training was relevant to their needs and if the course objectives and outcomes were met. Other questions focus on what difference the training will make to the work practitioners do and what aspects of the training could be improved. This allows training commissioners to measure what worked well and what improvements could be made in the future. A training needs analysis is also circulated across the service to gather information to inform the future programme.

Learning needs are also gathered from SARs. A SAR learning event was held, jointly with the SABs in neighbouring boroughs Barking & Dagenham and Redbridge, to explore what shared learning themes and challenges emerged from SARs and DHRs across the tri-borough area; how the learning themes help us understand what goes wrong; and establish what changes are required in order to reduce the likelihood of recurrence. A single action plan for relevant partner organisations with a focus on key thematic areas was created and signed off by the SAB.

The extent to which the SAB has been successful at aligning with other parts of the system, for example children's safeguarding and community safety

There has been strong partnership work across the SAB. ASC has worked closely with the Community Safety Team, particularly around both the Community and Domestic Violence MARACs, and increasing referrals from practitioners to these discussion panels. There has also been considerable partnership work around domestic violence, including increased practitioner awareness and providing support to victims of abuse.

There has been increased partnership working with Housing, BHRUT and NELFT around complex rough sleepers, homelessness, and self-neglect and hoarding. Work with Children's Services has been focused upon improving transitions and recognising exploitation.

In addition, Safeguarding Week 2019 enabled practitioners to work together on identifying new priorities arising from our changing population, and strategically plan our collective response.

How well agencies represented on the SAB have co-operated and collaborated

There is positive working between the key partners of the SAB and its related working groups; and agencies work well together to meet the priorities of the SAB and their own agency priorities.

There has been particularly positive collaboration between ASC and NELFT this year around partnership working on complex, high-risk cases. Going forward, ASC will work with NELFT colleagues to produce a procedure for the management of complex cases, building on existing mechanisms, processes, panels, and making improvements where necessary.

There has also been very positive partnership working with the Community Safety Team around the understanding of domestic violence, and issues including support and referrals for victims.

Going forward, ASC will continue further work with BHRUT and the CCG to improve discharge pathways and minimise appropriate discharges. We will continue to work with Housing colleagues to progress work around reducing and preventing homelessness.

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



**Barking and Dagenham,
Havering and Redbridge**
Clinical Commissioning Groups

How this service relates to safeguarding adults

Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) commission services from providers, including Care Homes, Hospitals and General Practices. The CCGs are responsible for seeking assurance that providers are fulfilling their legislative duties in relation to safeguarding adults in accordance with the Health and Social Care Act 2012 and the Care Act 2014. The CCGs also work in partnership with relevant statutory organisations to ensure compliance with national requirements.

Activity during 2019/20 to advance organisational safeguarding priorities

The BHR CCGs' Designated Nurse for Adult Safeguarding attends the tri-borough Liberty Protection Safeguards (LPS) Task and Finish Group, which has undertaken an assessment of the potential impact that the new LPS legislation will have across the boroughs of Barking & Dagenham, Havering and Redbridge. A significant amount of

work has been progressed to prepare staff and agencies for the implications of LPS when they come into force later this year.

Activity undertaken to support the SAB in meetings its key objectives

The BHR CCGs' Designated Nurse for Adult Safeguarding attends the SAB and a number of its subgroups, as well as representing the CCG at the Safeguarding Adult Review meetings and contributing to reports with information provided by GP Practices. She also participates in learning reviews and contributes towards action plans arising from the recommendations.

The Local Quality Surveillance Committee is chaired by the Designated Nurse Adult Safeguarding and continues to monitor quality and assurance and safeguarding issues and Care Homes with Nursing across the tri-borough partnership.

Regular updates are provided to the SAB on progress and recommendations from Learning Disability Mortality Reviews.

Obtaining the views of adults who have experienced the safeguarding process, and the extent to which the outcomes they wanted were realised

The Designated Nurse for Adult Safeguarding attends 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 includes speaking to adults and service users and seeking their views.

Obtaining the views of front-line practitioners about outcomes for adults and about their ability to work with them in a personalised way

The Designated Nurse for Adult Safeguarding fulfils the role of Local Authority Co-ordinator for the Learning Disability Mortality Review (LeDeR) Programme in North East London.

Briefings on LeDeR findings and recommendations have been submitted to the CCG's Clinical Quality Review Meeting (CQRM). Individual LeDeR update reports have been submitted to each of the three local authority Safeguarding Boards highlighting learning and omissions in care.

Anonymised reports are also sent to agencies who were involved in the person's care prior to their death so that good practice and omissions in care can be shared with relevant staff.

Activity undertaken to promote the better reporting of adult abuse and neglect

The Designated Nurse for Adult Safeguarding delivered Safeguarding Adult and Domestic Violence training for approximately 300 Havering GPs on 11/02/2020 as part of their PTI training sessions. The training was well received, and a number of the participants have contacted the CCGs for advice regarding patients with safeguarding concerns.

How agencies represented on the SAB have co-operated

Agencies represented on the SAB have co-operated and collaborated with contributions to learning events, progression of Safeguarding Adult Reviews, Modern Slavery work streams and the general requirements of Safeguarding Adults.

In Safeguarding Adult Reviews, agencies represented on the SAB work together to agree action plans when issues are identified that may have resulted in a different outcome for the subject of the review.

Safeguarding Update from Metropolitan Police East Area Basic Command Unit



Activity during 2019/20 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 (MPS) area.

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

MPS has increased training access. A specific Missing Persons course for Inspectors has been developed.

Obtaining the views of adults who have experienced the safeguarding process, and the extent to which they outcomes they wanted were realised

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

How we know that SAB training impacts on how people work and organisations change

SAB training can only ever be helpful. Knowledge and training are powerful tools that empower people. By building a network of people, you can maintain contact and call when not sure about things. It is okay not to know everything and, by having a network, it is a safe learning environment. This brings people together and adds value, and encourages partnership working, which is pivotal in change.

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



How this service relates to safeguarding adults

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

Activity during 2019/20 to advance organisational safeguarding priorities

The NELFT Safeguarding Strategy 2018-2021 builds on the NELFT Best Care Clinical Strategy. It reflects national policies and guidance to ensure NELFT continues to meet the statutory requirements. The strategy will be reviewed in 2020 to align with the Patient Safety Strategy.

The Safeguarding Standard Operating Procedures (SOP) were published in February 2019 and is reviewed regularly by the Safeguarding Team to reflect changes in legislation and procedures, and to incorporate learning from Safeguarding Reviews.

The NELFT Safeguarding intranet page provides a clear and more user-friendly page, enabling staff to source local information more efficiently. This has received positive feedback from staff who have reported that it is user friendly.

Learning has been incorporated into advice given via the NELFT Safeguarding Advice Service, which includes sign-posting and sharing information.

The Safeguarding Training Strategy has been reviewed in partnership with CCG partners and the Training department. This is to ensure a robust safeguarding training offer that remains compliant with the Safeguarding Adults Intercollegiate Guidelines (2018).

The Safeguarding Team is supporting inpatients by providing Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) bitesize learning sessions, and facilitating an audit on a frailty ward, in respect of whether the introduction of a DoLS Admission Screening Tool has had any effect on the number of DoLS applications made.

A Liberty Protection Safeguards (LPS) Task and Finish group is currently reviewing how NELFT implements the required changes in relation to LPS and is a core member of the Barking & Dagenham, Havering and Redbridge (BHR) LPS Task and Finish group.

Bitesize Exploitation training has been developed for practitioners and additional training in relation to Gangs, County Lines and Knife crime was commissioned to further support staff in Walk-in Centres.

The Protecting Adults, Young People and Children At Risk of Domestic Violence and Harmful Practices SOP was reviewed. These procedures have been separated into two documents in order to better support staff. The Domestic Abuse Staff Policy is currently being reviewed by Human Resources with support from the Safeguarding Team.

The Multi-Agency Risk Assessment Conference (MARAC) representatives support network has been re-established. The MARAC SOP and pathway is currently being reviewed to ensure a robust process for information sharing.

Activity undertaken to support the SAB in meetings its key objectives

- Attendance at joint SAB training.
- Support for the Safeguarding Adult Review process in partnership with other agencies.
- Regular representation on the Case Review Group, Quality & Effectiveness Group and Havering Safeguarding Adult Board Provider Meeting.

Obtaining the views of adults who have experienced the safeguarding process, and the extent to which they outcomes they wanted were realised

When practitioners contact the NELFT Safeguarding Adult Advice Service to discuss a safeguarding concern, they are reminded to seek consent and the views of the individual concerned, before raising a safeguarding concern to the local authority. Practitioners are also advised of hwn e exceptions to doing this would apply.

‘Making Safeguarding Personal’ is central to all safeguarding adult training and any advice provided.

Obtaining the views of front-line practitioners about outcomes for adults and about their ability to work with them in a personalised way

NELFT commenced our Making Safeguarding Personal audit at the onset of the Care Act in 2014.

Our focus is to engage with patients about the expected outcomes they want, which incorporates their views, wishes and beliefs throughout the adult safeguarding process.

Our safeguarding adults training for staff highlights the statutory requirements in obtaining informed consent from the adult at risk.

The importance of empowering patients, when possible, is included throughout the safeguarding process – advocating their views and wishes, and to make decisions about their care and safety – and this expected outcome is also included in NELFT training.

Activity undertaken to promote the better reporting of adult abuse and neglect

Work has also been progressed with both RiO and SystmOne EPR systems, to develop and strengthen the safeguarding adults template to support staff in identifying and recording safeguarding concerns and risk.

The NELFT Safeguarding Advice Service continues to operate during office hours, in order to support operational staff to both recognise and report abuse.

Bi-monthly Safeguarding Link Practitioner meetings continue in Havering, in order to support the development of a Safeguarding champion within each operational service.

A NELFT-wide Joint Link Practitioner Forum is held three times per year and invites Safeguarding Link Practitioners from both adult and children's services to come together and share learning and experiences, with an emphasis on 'Think Family'. The day is facilitated by NELFT Safeguarding Team and is supported by external speakers.

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



How this service relates to safeguarding adults

BHRUT is a large provider of acute services, serving a population of over 750,000 in outer North East London. The Trust operates from two sites: Queen's Hospital and King George Hospital. There are approximately 900 beds across both sites. The hospital includes a hyper acute stroke unit. The Emergency Department (ED) treats over 150,000 walk-in and ambulance emergencies each year.

The focus for the Safeguarding Adults Team during 2019/20 has been to progress the Trust's Safeguarding Strategy 2018-2020 and work towards our vision to uphold the rights of individuals to live free from harm, exploitation and neglect through a Think Family approach.

The Trust has continued to develop Safeguarding Adult Practice by responding to learning from safeguarding adult concerns and Safeguarding Adult Reviews (SARs) and ensures training has been aligned to the updated NHS England Intercollegiate Document.

Activity during 2019/20 to advance organisational safeguarding priorities

The Trust's Safeguarding Strategy (2018-2020) key priorities are:

1. Think Family
2. Service User Engagement
3. Responsive Workforce
4. Harmful Practice
5. Bridge the Gap for 16-to-19-year-olds
6. Empowerment and Advocacy
7. Learning From Practice
8. Information Technology

Particular areas to note:

Think Family

The Corporate Safeguarding Team have consistently promoted the 'Think Family' approach in training and supervision of staff. This is demonstrated in the increased number of referrals to the local authority.

The ED Safeguarding Advisors promote the 'Think Family approach' in meetings to ensure risks to are identified and acted upon.

Service User Engagement

Two audits on Making Safeguarding Personal were undertaken in 2019. One of the key findings identified that staff are gaining consent to raise a safeguarding referral and, if not, are citing a valid reason to override consent.

A patient partner is a member of the Trust's Safeguarding Strategic Group.

The Trust has two patient working groups for Dementia and Learning Disabilities.

Service Users are part of an ongoing maternity Domestic Abuse project. In

consideration to two recent maternity related Domestic Homicides, one of the victims being a member of staff, in February 2020 maternity initiated a Domestic Abuse Task and Finish Group project to explore initiatives that would allow the Trust to inform, educate and provide pro-active support to staff. This project was suspended due to COVID-19 activities, and is due to recommence in 2020 Quarter 1.

Empowerment and Advocacy

The first Dementia Café afternoon took place at Queen's Hospital at the end of May 2019, during Dementia Action Week. This was followed by one at King George Hospital in June 2019. These will continue on the last Wednesday of each month across both sites.

In the reporting year the MCA/DoLS Safeguarding Advisor actively supported staff to engage with the IMCA services, providing independent support – from Mind in Havering – to those patients that required a best interest decision to be made for serious decisions. During this period, 53 patients who had an urgent DoLS in place were identified as requiring support from IMCA services.

The Trust has a Safeguarding Audit Schedule 2019/20 and audit results are considered at the Trust's Safeguarding Groups.

Activity undertaken to support the SAB in meetings its key objectives

Throughout 2019/20, BHRUT have continued to contribute to multi-agency safeguarding practice and partnership working arrangements to ensure Havering service users are protected from harm. This has included attendance at all Havering SAB meetings, participation in the work of the SAB committees and subgroups, including Safeguarding Adult Reviews (SARs).

BHRUT has contributed towards Havering subgroups to deliver the SAB's work plan key priorities. The focus was maintained on key themes:

Mental Health

In this period 2019/20, members of the Safeguarding Adult Team worked closely with NELFT to support the development of the new Mental Health service. An Action Plan was developed which included the development of a MH policy.

Mental Capacity

Proactive engagement with IMCA service and facilitated training sessions to empower staff and support patients in their decision making.

Self-Neglect and Neglect

Awareness raising in training and cascaded learning by production of Lessons Learnt Bulletins.

Domestic Abuse

In light of Domestic Abuse, Domestic Homicides and Knife Crime, the electronic systems are being explored in relation to better capture information from which we can analyse data to improve service provision. The Safeguarding Team is also in the process of reviewing the Emergency Department Safeguarding Trigger Assessment Tool.

The Trust completed a Havering Safeguarding Adults Peer Review (Self Evaluation) in February 2020 at the request of the SAB. BHRUT's Director of Nursing and Safeguarding Director attended an evaluation event and present the Trust Evaluation Tool.

Obtaining the views of adults who have experienced the safeguarding process, and the extent to which they outcomes they wanted were realised

At present, service user experiences are primarily captured as part of case reviews and investigations following incidents. This is an area for development and will be considered as part of our next strategy.

Activity undertaken to promote the better reporting of adult abuse and neglect

Promotion of abuse and neglect has its basis on understanding and recognition of concerns. During this reporting period, there has been an increased focus on Domestic Abuse, and as part of an overall review, the Safeguarding Adult Level 3 training has been updated to provide up-to-date information on Domestic Abuse incidents, drivers and how to recognise it.

The ongoing Domestic Abuse Task and Finish Group project will include educational sessions on how to better recognise signs of neglect and empower to promote reporting.

We have introduced a new training video with scenario based role-play to support staff in the assessment and application of Mental Capacity Act. In addition to e-Learning, a further 54 face-to-face training sessions have been delivered including wards and outpatient departments, at essential training days for emergency department staff and midwives, at medical training sessions and with allied health professionals.

Nine workshop days, covering Dementia, Learning Disabilities (LD), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), have been delivered between 1 April 2019 and 31 March 2020.

Safeguarding Supervision and briefing sessions are held at ward level to review and reflect on incidents related to the recognition of abuse and neglect.

Susbtantial financial investment from the Trust in developing the role of the Dementia and Delierium Assistants who deliver patient-centred care and are key in the recognition of concerns and contribute to the unique safeguarding needs of the patient.

Learning Disability Awareness Training was provided by the Lead Nurse Learning Disabilities via the Trust's one-day workshop in collaboration with the MCA/DoLS advisor and Dementia Team, and in standalone sessions, all co-ordinated with people with a learning disability. Training for Doctors, Theatre staff and Trust Executives was also provided.

Activity undertaken to measure the impact of safeguarding training and analyse future need

Plans are in place to audit training using the Safeguarding Adults Framework. Case studies and incidents are shared via monthly Bulletins and used as a basis to measure front-line understanding of safeguarding emerging themes. During these discussions, gaps are identified and linked to training needs. During this reporting period, we have identified that Adult Level 3 required more focus on Domestic Abuse, and as a result this has been updated to provide evidenced information on Domestic Abuse drivers, signs and signposting.

The Safeguarding Children's Advisor, Learning Disability & Autism has developed a Tier 2 Autism awareness e-Learning package. This training will be reviewed and refit in the near future before going live on BEST.

A bespoke report regarding the outcome of the NHS Improvement Learning Disability Standards benchmarking exercise was received in July 2019; it demonstrated the Trust is performing well with regards to the care, resources and reasonable adjustments provided for people with learning disability accessing our hospital services.

Safeguarding Update from Havering Housing Services



How this service relates to safeguarding adults

Housing services to general needs tenants, Sheltered Housing residents, Hostels and Temporary Housing and HMO residents.

Activity undertaken during 2019/20 to advance organisational safeguarding priorities

Our priorities were:

- 1) To combat homelessness and overcrowding by increasing the stock of housing via a major regeneration programme.

The housing regeneration programme is ongoing, with a large number of new housing in the pipeline.

- 2) To further invest in Support Planning to enhance preventative measures and early intervention.

We have implemented support planning for our single, vulnerable residents living in HMOs (shared housing) and for our general needs housing; this has given us a much more comprehensive view of residents' needs and risk factors. We already complete support assessments with our vulnerable families living in hostels and temporary accommodation.

Activity undertaken to support the SAB in meetings its key objectives

We did a presentation to the SAB on the impact of Welfare reform, how Universal Credit has impacted on our residents and how we have supported them.

Obtaining the views of front-line practitioners about outcomes for adults and about their ability to work with them in a personalised way

We have regular contact with front-line staff, discussing safeguarding concerns and outcomes. This is in one-to-one meetings, team meeting and team briefings.

Activity undertaken to promote the better reporting of adult abuse and neglect

We contributed to the Safeguarding Week by presenting a seminar with Contractors and Caretakers explaining how safeguarding issues should be reported and the effect of not reporting safeguarding issues.

The extent to which the SAB has been successful in promoting community awareness of adult abuse and neglect and how to respond

There was a lot of publicity during the Safeguarding Week. This seemed successful in promoting community awareness.

How well agencies represented on the SAB have co-operated and collaborated

The partnership has worked well. There are some difficulties around Mental Health services, which are often to do with individual complex cases.

Safeguarding Update from Healthwatch Havering



How this service relates to safeguarding adults

We are a statutory organisation and our role involves working on some occasions with people who are vulnerable. This could be residents of care homes, people with learning disabilities, or people who are experiencing distressing matters related to health and social care.

Activity undertaken during 2019/20 to advance organisational safeguarding priorities

Our organisational safeguarding priorities are based on training and updating on good practice. We also have de-brief sessions of volunteer members have concerns.

Activity undertaken to support the SAB in meeting its key objectives

We ensure that our volunteer members are up to date with their training. At away days we provide updates which are appropriate for our member volunteers and this is undertaken by the volunteer member on the SAB.

Activity undertaken to promote the better reporting of adult abuse and neglect

Following Enter and View visits, the leader of the visiting team is required now to report immediately any concerns which have arisen during the visit. The assessment on how to take this forward with Havering Adult Social Care is now taken by the Company Secretary.

Activity undertaken to measure the impact of safeguarding training and analyse future need

Our organisation works through volunteer members. We have a comprehensive training programme which must be undertaken before visiting or other activities which involve meeting the public are undertaken. We have recently changed our training agency and now work with St. John's Ambulance using their system for safeguarding.

The extent to which the SAB has been successful in promoting community awareness of adult abuse and neglect and how to respond

There has been good progress with a successful approach. However, we also consider that this has to be continually reinforced and continually reviewed as to how best to ensure that the message is heard across all sectors within our community and continual reinforcement of how people should respond.

Safeguarding Update from the London Fire Brigade



How this service relates to safeguarding adults

The London Fire Brigade (LFB) act as a referral agent and are committed to working with partner agencies to ensure that fire risk is mitigated for those most vulnerable in our communities.

Activity undertaken during 2019/20 to advance organisational safeguarding priorities

A new LFB Safeguarding Lead was appointed last November who is currently undertaking a full review of all aspects of LFB Safeguarding from the policies, how referrals are made and captured, through to training.

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

Our officers provide the individuals at risk with comprehensive information about the risk they face, in order to encourage and empower them to take control of, and be involved in, identifying the best options to mitigate or reduce that risk. We have improved the organisational understanding of Making Safeguarding Personal through the roll-out of our new training package. Unless there are mental capacity issues (or other factors including our ability to do so), consent is sought from adults before safeguarding concerns are raised.





HAVERING SAFEGUARDING ADULTS BOARD

Annual Delivery Plan, 2020-21

This evidence-based delivery plan sets out our main objectives to ensure that local safeguarding arrangements and partner agencies act to help and protect adults in Havering.



Who we are

The Havering Safeguarding Adults Board (SAB) is a multi-agency partnership of key statutory organisations, non-statutory organisations and lay members in Havering. The Board comprises of senior members of those organisation who are responsible for robust and effective multi-agency policies, protocols and practices to safeguard adults from abuse.

Following the announcement in April that the Government would be launching a new national “CARE” brand for ASC, , the SAB along with its partners have had a role to play in ensuring citizens who needed support continued to receive the best possible care. It is the care and safeguarding of our residents that remains at the heart of Havering SAB.

Our statement of purpose

To ensure the effective co-ordination of services to safeguard and promote the welfare of adults in accordance with the Care Act 2014 and the Care and Support Statutory Guidance 2014. The Safeguarding Adults Board aims to achieve its objectives whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion. In achieving this, the following 4 key principles must be followed:

- Prevention: It is better to take action before harm occurs;
- Protection: Support and representation for those in greatest need;
- Partnership: Local solutions through services working with communities;


Our strategic plan will ensure that safeguarding policies remain under review during these challenging times.



Identified priorities

This delivery plan is informed by the learning from three recently concluded Safeguarding Adult Reviews commissioned by the Havering SAB, each of which has received full participation from involved agencies across the local partnership, and from audit and other quality assurance activity undertaken by the SAB's Quality and Effectiveness Working Group

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		consider three key objectives that the group could focus on. It was agreed that the key objectives that the group would focus on will be Self Neglect and Hoarding, Adult Exploitation (Criminal and Sexual including county lines and Modern Day Slavery), the impact of regeneration and demographic change and social isolation
<p>2. Protection</p> <p>Support and representation for those in greatest need, including identifying and protecting people who are unable to take their own decisions, or to protect themselves or their assets.</p> <p>Having in place effective systems and processes to support and safeguard the most vulnerable adults.</p>	<p>The Mental Capacity Act (MCA)</p> <p>The SAB will continue to seek assurance that the Care Act and Mental Capacity Act are being lawfully applied by partners and organisations</p> <p>The SAB will identify areas of weakness and support partners to address them.</p> <p>(The Mental Capacity Act: https://www.legislation.gov.uk/ukpga/2005/9/contents)</p> <p>Implementation of the Liberty Protection Safeguards</p> <p>The SAB will monitor the introduction of LPS across partners (deferred to 2022)</p>	<p>Multi agency MCA case audits will be carried out by the Q&E working group to inform the training and guidance required for practitioners actions 1.1/1.2 and 3.2</p> <p>The SAB will undertake an audit in January 21 using the Safeguarding Adults at Risk Audit Tool (SARAT)</p> <p> 2018_19 Safeguarding Adult:</p> <p>A task and finish group for MCA will be convened via the Havering Social Care Academy (HSCA) to enable direct workers in Adult Social Care to develop legal literacy and become MCA champions and provide peer support</p> <p>BHRUT and NELFT will review the guidance for an inpatient with mental health needs who is being discharged</p> <p>ASC will continue to brief practitioners on the referral process for residents who are self-neglecting/hoarding and design a mechanism into Liquid logic for this to be measured</p>

	<p>Implementation of the Liberty Protection Safeguards (LPS) The SAB will monitor the introduction of LPS across partners (deferred to 2022)</p> <p>The identification and co-ordination of high risk and complex cases The SAB will continue to support the development and usage of process to strengthen the coordinated multi agency responses to high risk and complex cases</p>	<p>CCG will design an innovative training package to aid improvement of mental capacity assessments, skills and documentation.</p> <p>BHRUTs Prevention and Treatment of Pressure Policy will include a flow chart for the process of reporting pressure ulcers and also give regard to safeguarding</p> <p>A multi-agency task and finish group has been formed to agree a strategic approach to the changeover from the current Deprivation of Liberty Safeguards (DoLs) system to plan for the implementation of LPS in 2022</p> <p>Current multi-agency risk assessment Panels will continue to be reviewed and streamlined in order to effectively monitor complex cases</p> <p>Shared safeguarding supervision principles highlighting early identification of complex risk actions to be produced at a virtual group</p> <p>An on-line public facing decision tree risk assessment tool is being developed by ASC to support early decision making</p> <p>GP safeguarding adult policies are currently being reviewed. In the meantime GP's have been provided with a flow chart on what to do when an adult is at risk of significant harm</p>
3. Partnerships	Learning from Safeguarding Adult Reviews (SARs)	

<p>A) Multi-agency Partnership Agencies across the multi-agency partnership work together to recognise and respond to indicators of abuse and neglect.</p>	<p>The SAB will undertake SAR's in line with the Care Act requirements and ensure learning from local regional and national SAR's is embedded locally and influences outcomes</p> <p>Covid-19 COVID 19 has presented significant challenges to the ability of agencies to safeguard the most vulnerable. This has led to a different way of thinking and working and has led to a change in the cohort of individuals who may be now considered vulnerable</p> <p>Training The SAB will continue to work with partner agencies to develop a training programme</p>	<p>The SAB has had a number of SARs and has compiled a multi -agency action plan to ensure the learning from these is embedded into practice across the partnership. The action plan will continue to be reviewed monthly until all recommendations/actions are completes.</p> <p>Throughout the pandemic, health and social care shared access to crucial PPE supplies so that services could continue to operate safely. This support of each other's service areas will continue to safeguard our residents</p> <p>The SAB will produce and distribute 7-minute briefings on each of Havering's SARs and the DHR; and, based on the Care Act and pan-London procedures, how to recognise and respond to individual forms of abuse and neglect, so that this information can be disseminated in an accessible format across the multi-agency partnership.</p> <p>The SAB will initiate a Safeguarding Health Check survey for staff across the adults' multi-agency safeguarding partnership.</p> <p>ASC to design and implement a structured induction and tailored case load and supervision arrangements for unqualified workers, including care assessors; this to include improved access to training and development opportunities and shadowing opportunities to visit other teams</p> <p>Havering Social Care Academy to work with the NELFT Social Care Lead for Mental Health to benchmark 'mental health competencies' for different roles</p>
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<p>3b Community Engagement The wellbeing and safeguarding of Havering residents is the primary aim of the SAB.</p> <p>In order to achieve this, the voice of the community, service users and staff needs to influence safeguarding responses.</p>	<p>Information Sharing</p>	<p>(potentially informed by the following framework: https://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework)</p> <p>Havering Social Care Academy and NELFT to develop an offer for online and face-to-face training on mental health, domestic violence and harmful practices</p> <p>SAB to develop a bespoke training plan with Housing in response to the last 2 SARs</p> <p>BHRUT to undertake an audit of staff knowledge and an evaluation of staff training using the Safeguarding Adult Framework.</p> <p>Multi agency partners to work together to identify frequent attenders to ED and formulate a management plan</p> <p>ASC, CCG and named GP lead for safeguarding to develop awareness of GP responsibilities</p> <p>A new independent SAB website is being developed, ensuring that contents are accessible and user friendly to residents and partners.</p> <p>The SAB will continue to work with partners to develop a robust engagement policy with people who have experienced safeguarding services.</p> <p>The SAB will establish direct channels of communication with residents through partners and community groups in order to receive feedback.</p>
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