BARNET LONDON BOROUGH

METROPOLITAN POLICE Working together for a safer London

NHS North Central London

# Barnet Safeguarding Adults Board 2011-12

# Annual Report

This report outlines the work achieved by Barnet's multi-agency Safeguarding Adults Board during 2011-12

LFB LONDON FIRE BRIGADE

barnet homes

LONDON AMBULANCE SERVICE

CommUNITY Barnet

Royal Free London NHS NHS Foundation Trust

Barnet, Enfield and Haringey NHS Mental Health NHS Trust

Barnet and Chase Farm Hospitals NHS NHS Trust

## Contents:

## Forward

This review sets out the work of partner agencies who have a shared responsibility for the safeguarding of vulnerable adults in Barnet. The report sets out facts and figures about the volume of referrals that are received by Barnet from different sources. Each statistic represents a person or a family who are struggling to keep safe and to get good enough care.

Most informal and paid carers provide excellent care and most communities are respectful of their more vulnerable members but for some this is sadly not so. Adults-at-risk can face abuse and hostility, neglect or cruelty, whether this is the taunting of a disabled person by local children or the rough handling by a care worker who is having a difficult shift. Occasionally the abuse is more planned and deliberate and these are cases that shock the public and that cause fear and concern to older people and people with mental health or learning disabilities. We also have ongoing issues to attend to such as how to support people with learning disabilities in hospital, how to ensure older people are treated with dignity and respect and how to provide consistently good nursing care in both hospitals and nursing homes.

So this report is not designed to shock but to affirm the fact that Barnet agencies take abuse and neglect seriously and follow up cases of them rigorously.

The Safeguarding Adults Board brings together representatives of all the key statutory agencies whose expertise may be needed to put things right when they have gone wrong.

We operate a “no wrong door” policy so that whoever you trust with your concerns or complaints, they will be routed to the responsible body who can conduct an investigation, take steps to keep you safe and if necessary to act against a person who has harmed a vulnerable adult or a service that has failed in its duty of care. You will see the statements made by each of these agencies about their work over the past year and begin to see how complex this task is, but also how committed each agency is.

We want to ensure that these safeguards are applied to vulnerable people from all communities and rely on the support of our Faith and Communities sub-group to inform and challenge us in doing so. We also regularly consult our User and Carer Forum who have helped us particularly this year by drawing up a clear mission statement to guide us as we prioritise the many issues that come within our remit.

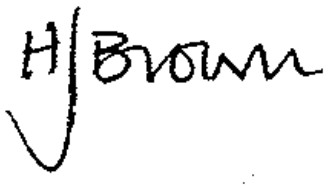
During 2011-2012 we have faced the challenges of reorganisation and changes to the way services are commissioned, delivered and overseen. We all know that there are cuts in the funding available to provide services and that despite these there is support for new ways of trying to offer services that improve choice and accessibility while also being cost efficient and flexible. The Safeguarding Adults Board tries to “stay ahead of the game” by anticipating any ways in which people might be made more vulnerable than they need to be, and by building safeguards into new systems such as direct payments or self-directed care. We look for ways we can learn about hidden problems for example by monitoring pressure sores, or creating third party reporting sites which allows anyone who has disclosed abuse to one agency to report that into the central system with the person’s consent and cooperation.

This year we have worked hard to address the issues of hate crime and of self-neglect. We have to find the right balance between being too interfering and at the other end of the spectrum, turning the other way when some very vulnerable people are out of their depth. Of course we don't always get it right, and sometimes we find ourselves unable to find the right ways to unlock a person's fearful avoidance of change or the right constellation of sticks and carrots to take action against a neglectful or negligent service but we are always learning and facilitating this through training and raising awareness. The Board acts together to find ways through these difficulties, not in relation to particular individuals but by setting up the infrastructure that allows agencies to work together when faced with difficult situations and hurt people.

Adult Social Care and Health are charged with coordinating this work, but it is the Board that makes this shared challenge a reality. We work pragmatically and carefully, learning from difficult cases and sharing good practice and creative ideas. No-one wants to become a "case" any more than any of us want to be seen as a "statistic." The work of partner agencies in assuring that services are safe and sensible helps to avert this possibility for most people and most families for most of the time. We prioritise investment in training staff across all sectors as one route to this sharing of responsibility.

The Board has a number of sub-groups who inform us and feed into our deliberations. The User and Carer Forum keep our work grounded and relevant. The Faith and Communities sub-group is working to raise awareness and to keep channels of communication open. Safeguarding is everyone's business and we need to be learning about the issues that concern you from your community leaders but also to work through your local networks to make sure people know where to report difficulties and how to make sure you get a fair deal if you or a relative have been harmed or treated badly. We link in with the Provider Forum and we are building strong working relationships with the domestic violence services and with the Community Safety Unit.

Ultimately the test of our work lies not in the figures assembled here but in whether vulnerable people living in Barnet feel safe in their homes, when they receive care, when they move about their community and in their workplaces and leisure activities. We take the safety of older people and people with disabilities very seriously whether that means protecting them from one-off instances of abuse or from more pervasive and longstanding failures in care. Their rights to citizenship and dignity are jeopardised if we do not act on their behalf when they are abused or denigrated. The Board's job, as evidenced in this report, is to work together, across all agencies, to make these Safeguards the best that we can.



**Prof. Hilary Brown,**

**Independent Chair,**

**Barnet Multi-Agency Safeguarding Adults Board**

# Barnet Multi-Agency Safeguarding Adults Board

# Annual Report
# 2011 – 2012

## 1 Introduction

Barnet's Safeguarding Adults Board was established in July 2001. It is made up of senior officers from the different public services who work with vulnerable adults in Barnet. The Board has four main aims:-

- To promote the welfare of vulnerable adults and to develop good practice in health and social care services.
- To raise awareness of abuse wherever it should occur and encourage people to report it if it happens.
- To ensure that agencies will work effectively together to ensure abuse is investigated and that people are helped to keep safe.
- To learn lessons where people have not been adequately protected.

The Board meets four times a year and is chaired by an independent person, Professor Hilary Brown. The Safeguarding Board has to report on its work to Council members via the Safeguarding Overview and Scrutiny Committee and the Health and Well-being Board in the Council. In addition the annual report will go to each members executive Board, the Safer Community Board and to each care group partnership board for information. It will be made available to the public on our website at www.barnet.gov.uk/safeguarding-adults-board

This annual report tells you:

- Who we are
- What work we have done in the last year
- What the statistics tell us about abuse in the Borough
- What work we plan to do in the coming year.

## 2 Who we are

The Safeguarding Adult Board membership includes people from:

- London Borough of Barnet
  (Adult Social Care & Health, Children's Safeguarding, and Community Safety)
- NHS North Central London
- Barnet, Haringey and Enfield Mental Health Trust
- Barnet and Chase Farm NHS Trust
- The Royal Free NHS Trust
- Central London Community Health Care
- The Metropolitan Police

- The Care Quality Commission
- Barnet Homes
- The London Fire Brigade
- The London Ambulance Service
- GP representative
- Barnet Carers Network
- Voice Ability (Independent Mental Capacity Advocate Service)

## 3 Safeguarding Adults Service User Forum

Our Safeguarding Adults Service User Forum continues to ensure that the voice of service users remain central to our safeguarding work. The forum meets quarterly, and consists of representatives of the 55+ forum, Barnet Older Peoples Assembly, Barnet African Caribbean Association, Barnet Older Asian Association, Barnet Voice for Mental Health, Barnet People's Choice, and other interested older people, people with learning disabilities, physical disabilities and sensory impairment. This year they have developed their own mission statement.


### 3.1 Mission Statement

"**Our mission is to play a significant part in the community by raising awareness amongst the public, and training those who live and work with vulnerable adults; to protect and help them, and establish good practice throughout our community**

Helping vulnerable adults is the central feature of Barnet's Safeguarding Adults Forum. Vulnerability takes many forms and can be experienced at any age, so the "safeguarding" policies and ideas have to develop in many ways. That's what our Barnet Forum aims to do.

- It means creating awareness about abuse of vulnerable adults.
- It means creating methods of communication and information wider than among those directly affected.
- It means helping to give confidence to vulnerable adults to deal, or to be a crucial part in dealing with, these problems.
- It means helping them to become as much a part of mainstream life as possible.
- It means helping to establish good practice amongst those who provide health and social care.

- It means seeking to work collaboratively with the various agencies and networks of our local community.
- In total, it means working to create a better thought culture about dignity, equality and human rights.

**Playing a significant part in this community endeavour is our aim and mission.**

Each forum receives a progress report from the Board and a presentation from one of the agency partners. Members of the forum are encouraged to challenge and scrutinise agency plans for safeguarding adults who use their service. For example this year the Royal Free Hospital was required to report on the findings of an inspection conducted by the Care Quality Commission and to report on how they planned to make improvements in treating their patients with dignity. They also reviewed what information is available to members of the public on recognising and reporting abuse. Following the screening of the Panorama programme on Winterbourne View they requested a report from the Learning Disability Service on how they are keeping people safe. They have also received presentations about advocacy in care homes, and about financial abuse. They have received statistical information on referrals and outcomes.

### 3.2 What the Forum has done in 2011/12:

- We know about the work of the Safeguarding Adults Board, and through presentations we have had an opportunity to question, challenge and influence the work of the Board.
- We have developed a mission statement
- We know about financial abuse and how to protect our finances, and some of us have arranged for presentations on this subject within the organisation we represent.
- We have helped develop accessible information about what happens after abuse is reported so more people are better informed.
- The Royal Free Hospital told us about their inspection and what they are doing to ensure their patients are treated with dignity and respect

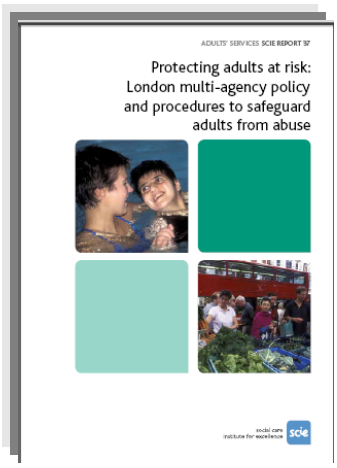
**Alan, Ann, Yuki and Carl**

"The Safeguarding User Forum is good because it is important to:

- receive information
- stop bullying and harassment and help others
- learn how to be safe and independent."

- We know that pressure ulcers are a sign of neglect
- We know how advocacy is working in care homes for older people
- We know more about hate crime, and some of our organisations continue to be third party reporting sites to make it easier for people to report
- We have received a report from the learning disability service on their work to safeguard people following winterbourne view.
- We have provided advice on the development of interview questions to find out what people who have been abused think of safeguarding services
- We have provided advice on the development of information about staying safe.

## 4 Safeguarding Across London




Up until last year each local area had developed their own policy and procedures to safeguarding adults at risk. Across London we recognised the value in coming together to develop pan London arrangements for safeguarding, as many agencies such as the Police, Health Trusts, and other services work across different Boroughs. Therefore Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse was developed and endorsed by the Police, Health and Adult Social Services departments. It was introduced in Barnet in October 2011. Although arrangements for reporting and responding to abuse will remain the same, a London wide approach will provide greater consistency and improved joint working.

Briefing sessions on the new policy were delivered to update staff, partnership boards, provider and community forums. Each agency has amended their internal procedures in line with this new Policy. You can see the document at www.barnet.gov.uk/safeguarding-adults Further practice guidance for staff is due to be published later this year.

## 5 Safeguarding In Health

5.1 All our NHS partners have established an internal Safeguarding Group to ensure patients in hospital and those receiving health services are treated with dignity and respect, that the most vulnerable patients receive the care they need, and that if things go wrong this is taken seriously, investigated thoroughly, and work done to prevent it happening again. The department of health issued some guidance last year to assist Health managers with this work. A statement from each Health Trust outlining their progress and work planned for the future can be found in the appendix of the annual report. **The Safeguarding Adults Board requires each Health partner to report on their plans and the progress they have made on a scheduled basis.**

5.2 All NHS partners have programmes in place to ensure that patients are treated with **dignity and respect.** The Care Quality Commission inspected each of the hospitals to find out how they were treating patients and checked if they were getting nutritious food. They found that a number of hospitals including the Royal Free Hospital were not doing enough in this area. As a result each of our NHS partners were required to report to the Board on the work they are doing and what patients think of the service. The Royal Free Hospital reported to both the Board and the service user forum on the findings of their inspection and their action plan for

improvements. The Care Quality Commission has since checked if these plans are working and were very pleased with the progress.

5.3 In order to safeguard the most vulnerable patients from abuse and neglect NHS London has directed all local health trusts to report all **pressure ulcers of grade 3 and 4 into the safeguarding adult procedures** as they can be a sign of neglect. Central London Community Healthcare NHS Trust has ensured there is a high priority given to the rapid identification and treatment of pressure ulcers. A specialist nurse in this area (A Tissue Viability Nurse) has worked closely with other nursing staff both on wards and in the community to ensure they have the necessary knowledge and skills to provide the best treatment. Those teams with the highest incidence have been targeted. They have also introduced a monthly reporting system, and developed information for patients seen by a community nurse. They have set a target to reduce grade 3 and 4 pressure ulcers by 50% in 2012-13.

5.4 All the NHS Trusts have extensive training programmes for staff and details of this can be found in section 7.

5.5 Barnet General and the Royal Free Hospital each have an Acute Liaison Nurse for people with learning disabilities. Their job is to ensure that people with learning disabilities can access services within the hospital, and that staff on wards can make reasonable adjustments to make sure their health needs are met. The nurse also supports individual patients who might be anxious about coming into hospital.

5.6 Barnet General Hospital has also reported on the work they are doing to help people with dementia in hospital, like the introduction of the 'green cup scheme' to help prevent people how have dementia becoming dehydrated.

5.7 The London Ambulance Service made 368 referrals to Adult Social Care for Barnet residents, who they were concerned about requiring an assessment

5.8 Each Health Trust has systems in place to check they are safeguarding patients properly. At the Mental Health Trust and the Royal Free, this includes checking case files and records. All Trusts regularly ask patients about their experiences of using Health services. The Royal Free invited an external person to look at their work, they found that staff had good awareness of abuse and made some recommendations about improving training. NHS North Central London hold regular meetings with hospital Trusts to talk about the quality of patient care including how well they are safeguarding patients.

## 6 Working to improve services

When Adult Social Care purchases a service from an agency such as a care home, we ensure that a contract is in place to spell out the requirements and quality of the care to be provided. A 'safeguarding adults' specification is included in these contracts including residential and nursing care, supported living and home and community support. For example contracts state that providers will:-

- Ensure staff have been checked as suitable to work with vulnerable adults
- Train and supervise their staff to set standards
- Work to local safeguarding policies and procedures
- Have a whistleblowing policy

Quality monitoring procedures are in place to check compliance with the contract through scheduled visits. This provides an opportunity for us to find out how services are doing, and to address issues early to prevent them from escalating. Where things do go wrong we work closely with the Care Quality Commission to seek improvements and ensure those people that use services are safe.

A Provider Forum has been established to help people who provide services, like care home managers to come together to share good practice, learn about new developments and ensure service users receive the best possible care.

6.1 Barnet has a 123 care homes in the borough, as part of our drive to improve quality we have commissioned the **My Home Life Project**. This is the second year of the project which is a UK wide programme, promoting quality of life for older people in care homes, and for those visiting and working with them. It is led by Age UK, City University and the Joseph Rowntree Foundation. The project uses best practice and creates support for practitioners and provides accessible tools and information resources for care home mangers and staff and commissioners. It highlights the specific practices, behaviour and attitudes which impact on quality of life in care homes.

What care home mangers said about the My Home Life Programme?

*"Everything is down to the manager – your finger must be on the pulse and you have to lead by example"*

*"It has been empowering" "the things I am doing differently are time management, leadership for the trained nurses, and approaching relatives differently*"

6.2 The television programme Panorama showed the horrific treatment of people with learning disabilities in a private hospital called **Winterbourne View**. As a result the Board requested a report on the numbers of people with learning disabilities who are in a private hospital and the arrangements for ensuring these placements are suitable, safe and provide a high quality of care. This will continue to be monitored by the Board in 2012/13. A learning event on Winterbourne View was delivered to staff in the Learning Disability Service, and staff working in commissioning and contract monitoring as part of Safeguarding Month.

6.3 The London Fire Brigade carried out 2681 free home fire safety visits to Barnet residents in 2011-12 many of whom are vulnerable people.

## 7 Making sure all staff know how to safeguard adults

7.1 The Safeguarding Adults Board plans a range of training and learning activities for staff across the workforce to ensure they know how to safeguard adults. This year the Board **Revised** all training in line with the new publication; *Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse* and the new **national safeguarding adults competency framework.**

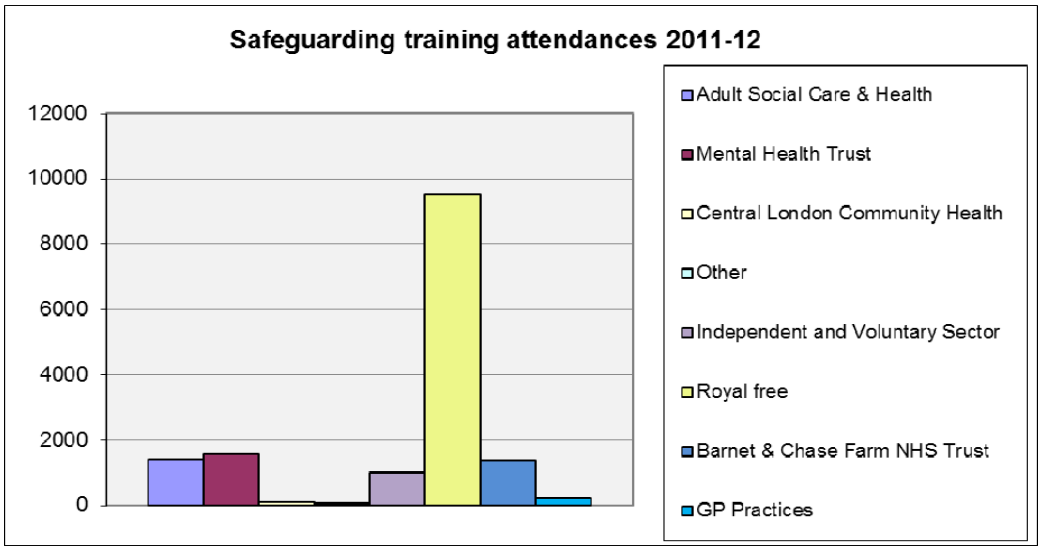
7.2 The training programme for 2011-2012 was delivered to Barnet Council staff including Adult Social Care & Health, Barnet, Enfield and Haringey Mental Health Trust, CLCH, and the private, voluntary and independent sector organisations in Barnet. We also trained Council Members. The core training included awareness sessions, policy and procedure training, and

Safeguarding Adults Investigations. **The total number of health and social care staff who attended these sessions is 1299.**

7.3 In addition the following training was provided at the different hospital sites in 2011/12

- The Royal Free NHS Trust delivered Safeguarding Adult training at level 1 to 6489 staff and level 2 to 3012 staff (safeguarding awareness) and a further 32 were trained to level 3.
- Barnet and Chase Farm NHS Trust delivered safeguarding raising awareness sessions to 1385 clinical and non-clinical staff across the two sites.
- Barnet staff working for Central London Community Health Services trained 80 staff as part of a raising awareness programme.
- Barnet, Haringey & Enfield Mental Health Trust have trained 1761 staff across the Trust.
- 234 staff from GP practices were trained.

7.4 The chart below shows attendees from each of the agencies.




7.5 50 training sessions were delivered to staff working in care homes and home care services, **on-site at their premises.** This meant that whole teams could receive the training together, and focus on improving practice in their particular setting. This type of training is very popular.

What managers said about the training in care homes:

*'It was very good and very educational. I learnt things I thought I knew but didn't'*

*Excellent - very well delivered, very clearly structured, informative and interesting. Thank you very much!"*

7.6 An Investigations Training programme was delivered to 15 managers of care homes and other services to improve the quality of investigations in these settings.

7.7 Safeguarding practice forums are run quarterly to supplement the formal training programme. One aimed at social workers and other front line practitioners, the second is a forum for senior social workers and managers. Both aim to **enhance good practice**, update on practice developments and provide support to these staff so they can become safeguarding champions in their teams.

7.8 Four training sessions were given to carers on financial abuse and protecting finances

This is what carers said about the training:

*"found the session very informative" ."this excellent session should be made available to more people"*

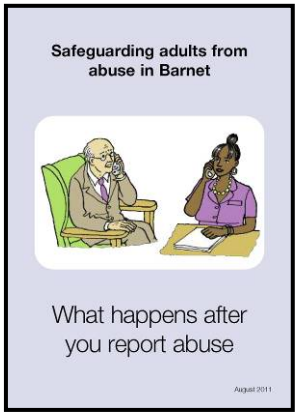
*"it was good because it made us aware of the services and back up available"*

## 8 Letting people know what safeguarding is

The Safeguarding Adults Board has set up a communications group. They work to increase public awareness of all types of abuse and raise the profile of safeguarding amongst health and social care providers and professionals.

### What have we achieved this year?

**Raising public awareness**:




- We worked with the Safeguarding User Forum to develop a new accessible booklet about what happens after you report abuse
- We took part in the national World Elder Abuse Awareness Week during June 2011. We focused our activities on raising awareness of financial abuse with different community groups and voluntary organisations in Barnet
- We made sure that all new booklets, like the Barnet Care Directory, included safeguarding information
- We are producing fact sheets for people who receive Direct Payments on how to safely recruit a PA
- We published local newsletter articles about safeguarding to coincide with the local launch of PAN London Safeguarding Adults Policy and Procedures in October 2011
- We developed a safeguarding information page for social care providers on Barnet Online
- We have created a poster to raise awareness of whistle blowing procedures for staff within social care organisations for distribution to all social care services.

## 9 Community Safety

9.1 The Community Safety Partnership Board recently undertook a review of local arrangements to prevent and respond to hate crime in the Borough.

Disability related hate crime is often under reported, so a large conference on **Disability Hate Crime** was run to raise awareness amongst adults with learning disabilities. The event, organised by Barnet Voluntary Sector Organisations, the Police, & Adult Social Care & Health, was attended by 108 people.

The day was introduced by the Mayor. It was led by Barnet Mencap who, through the use of actors (including some with learning disabilities), presented real life scenarios to explore the realities of disability hate crime, which were discussed in subsequent workshops. You can see a video of the performance "What is Hate Crime?" by Biscuit Company here: www.youtube.com/watch?v=i7X89eGYO1s

**Donna**
"The day was powerful, emotive and real for me. A strong message is needed to help people understand how important it is to know how to deal with hate crime. It is empowering to know what to do, if a situation arises"


*Everyone at the conference was given this information card to put in their travel card. It gives information about what is hate crime and where to report it. This includes all the places you can go which are accessible to older and disabled people. These are called third party reporting sites.*

9.2 A domestic homicide review was conducted following the death of a Barnet resident. A number of recommendations will be made as a result of this review, and the Safeguarding Adults Board will need to review these recommendations for any action to be taken by partner agencies.

## 10 Faith and Culture Group

The Faith and Culture Group aims to promote partnership with minority ethnic, faith and culture groups with the broader aim of raising awareness of safeguarding responsibilities and encouraging good practice in working with children and vulnerable adults. The group reports to both children and adults safeguarding boards. The group's work has focused on **building links** with communities, in order to understand why it is difficult for some community groups to report abuse, and what support they need. The group also carried out a survey on staff to find out what they know about Barnet's diverse communities and what help they need to work better with all adults.

## 11 Mental Capacity Act and Deprivation of Liberty Safeguards

### 11.1 Mental Capacity Act

The Mental Capacity Act 2005 for England and Wales supports and protects people who may be unable to make some decisions. Every day we make decisions about lots of things in our lives. The ability to make these decisions is called mental capacity.
People may have difficulties making decisions some or all of the time. This could be because they have:

- a learning disability
- dementia
- a mental health problem
- a brain injury

The Mental Capacity Act covers major decisions about someone's property and financial affairs, health and welfare and where they live. It also covers everyday decisions about personal care (such as what the person eats), when the person can't make those decisions for themselves.
This means if you are unable to make some decisions, the Mental Capacity Act says:

- you should have as much help as possible to make your own decisions
- people should assess if you can make a particular decision
- even if you cannot make a complicated decision for yourself, this does not mean that you cannot make more straightforward decisions
- even if someone has to make a decision on your behalf you must still be involved in this as much as possible
- anyone making a decision on your behalf must do so in your best interests

An **Independent Mental Capacity Advocate** is someone appointed to support a person who lacks capacity and has no one to speak for them. Independent Mental Capacity Advocates only become involved when certain decisions need to be made involving a change of a person's accommodation where it is provided by the NHS or local authority or about serious medical treatment. They can also be involved where there are safeguarding concerns whether or not family, friends or others are involved. The Independent Mental Capacity

Advocates (IMCA) Service is represented on the SAB and provides quarterly reports on its work.

| Source of Referral to IMCA | Number |
|---|---|
| Local Authority | 67 |
| Health Authority | 21 |
| Total number of referrals | 88 |

*Of these referrals the majority were concerned with decisions relating to accommodation. The numbers relating to safeguarding (6) and serious medical treatment (9) remain low.*

The Safeguarding Adults Board has recognised the need to raise awareness of the Mental Capacity Act by health organisations and practitioners. There appears to be a particular lack of knowledge amongst community health staff and GPs.

In response the Board planned a multi-agency conference to raise awareness of the Mental Capacity Act: "Whose decision is this?" 162 people attended two half day session facilitated by AFTA Thought who, through the use of actors and training facilitators, presented real life interactive scenarios to explore the **practical application of the Mental Capacity Act** amongst health and social care staff across the workforce.

What staff said about the Mental Capacity Act Training?

*Brilliant – brought the Mental Capacity Act and DoLS to life!'*

*'This is the best training ever. It is very innovative'*

There has been an increase in applications to the Court of Protection from the Local Authority in relation to tenancy agreements. This is related to the general move from residential care to supported living for people with learning difficulties.

## 11.2 Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act (2005). They aim to protect people in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards have been put in place to make sure that a care home or hospital only restricts someone's liberty safely and correctly, and that this is done when there is no other way to take care of that person safely. The safeguards apply to vulnerable people aged 18 or over in hospitals and care homes who are unable to make decisions for themselves but who may need treatment or care to keep them safe and who are not detained under the Mental Health Act. Dols came into force on 1 April 2009. They are designed to

ensure that a person's loss of liberty is lawful, and that they get the special protection they need.

Barnet continued to receive a relatively high number of requests for DoLS assessments throughout 2011/12. The Local Authority received a total of 43 requests, which is the second highest in London. The table below shows the outcome of these requests.

| | 2099-10 | 2010-11 | 2011-12 |
|---|---|---|---|
| Number of requests for authorisation | 80 | 21 | 43 |
| Number of authorisations granted | 23 | 11 | 24 |
| Number with conditions attached | 15 | 10 | 18 |
| Number of authorisations failed | 54 | 8 | 20 |

Barnet PCT received a total of 21 requests, which represents a significant increase and is the highest in London. In 2013 the duties of the PCTs for receiving Dols requests will pass to the Local Authorities. Given the high numbers of referrals, this may well have an impact upon capacity to respond and work is currently being undertaken to prepare for this change.

CQC have recently published their 2nd annual report on the use of DoLS in care homes and hospitals which can be accessed via http://www.cqc.org.uk/dols. Overall, CQC found that not everyone knew enough about DoLS and there were differences in different parts of the country. This is broadly what we found in Barnet, so more work is needed to ensure all staff know about DoLs.

## 12 Learning from experience

Last year the Safeguarding Adults Boards in Barnet and Enfield worked together to learn lessons from a case where a young man with learning disabilities died in a care home. An independent person looked at what went wrong and made recommendations of how to improve things to prevent such a tragedy happening again. The Safeguarding Board made sure all these recommendations were acted on by the different agencies. This year the Board planned an event for staff to make sure everyone could learn from what went wrong. The event, held in September, was attended by 160 professionals and care home managers. In the morning, staff who commission and monitor services came together with health and social work professionals from the Learning Disability Service to focus on planning improvements. In the afternoon, managers who run services for people with learning disabilities from the two Boroughs met to learn about the safer recruitment of staff, risk assessment and working in partnership. The day was hosted by the Director of ASCH and Prof Hilary Brown.

What staff said about the learning event:

*"Excellent learning event and very moving"*

*"A good informative event"*

*"Very interesting and helpful"*

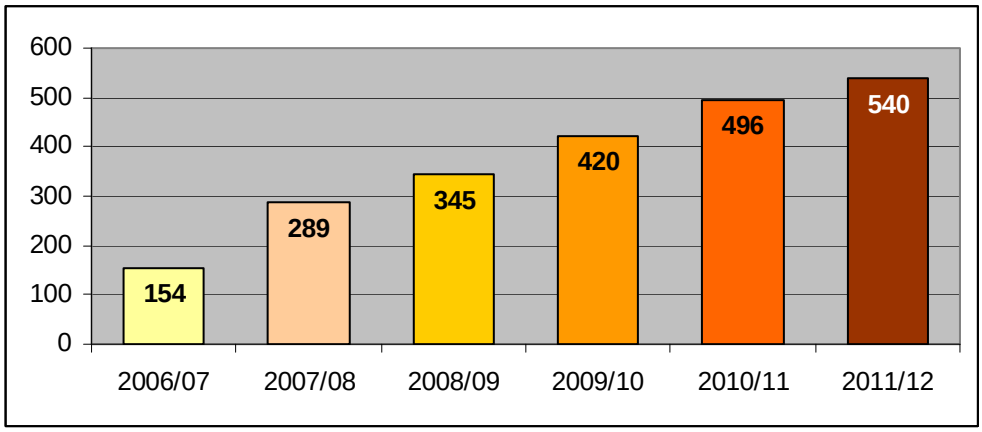
12.1 When there is a fire death involving a vulnerable adult the Safeguarding Board will find out more information to see if more can be done to keep others safe from fire in the future.

## 13 What the statistics tell us

We collect information about our work, so we know how well we are safeguarding people. This information helps the Safeguarding Adults Board decide what their next steps should be.

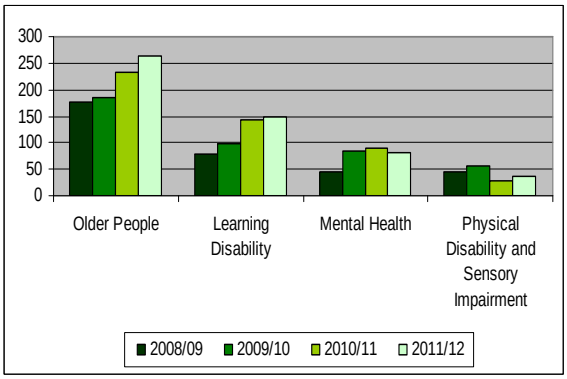
We received a total of 540 alerts in 2011/12. Every year we have seen an increase in alerts as more people know about abuse and where to report it.

The table below compares the numbers of alerts per year since 07/08.




### 13.1 Who is at risk

As in previous years, most alerts we receive concern the abuse of older people. The table below shows the breakdown of all our safeguarding alerts by the adult at risk's primary need. There has been an increase in the numbers of older people, adults with learning disabilities and physical disabilities referred during 2011, and a small decrease in the numbers of alerts involving adults with mental health problems.




| Primary Client Group | 2008/09 | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|
| Older People | 51% | 44% | 47% | 49% |
| Learning Disability | 23% | 23% | 29% | 28% |
| Mental Health | 13% | 20% | 18% | 16% |
| Physical Disability & Sensory Impair. | 13% | 13% | 5.5% | 7% |
| Substance Misuse | - | - | 0.5% | - |

**A total of 142 adults referred were recorded as having dementia**, this is an increase from 95 last year. 43% of all alleged abuse affecting people with dementia was caused by care home staff.

## 13.2 Age

Over half of the adults referred in 2011/12 were over the age of 65, and nearly a quarter aged 85 or over. This largely reflects the age profile of Barnet service users receiving a care package, although safeguarding cases involve higher proportions of younger adults, particularly those aged between 30-44, and a lower proportion of older adults, particularly those over the age of 85.

| | 18-44 | 45-64 | 65-74 | 75-84 | 85+ | N/A |
|---|---|---|---|---|---|---|
| Safeguarding cases, 2011/12 | 143 | 103 | 65 | 97 | 126 | 6 |
| | 27% | 19% | 12% | 18% | 24% | |
| *Care packages, 2011/12* | *18%* | *17%* | *11%* | *22%* | *33%* | |

## 13.3 Gender

42% of all cases concerned men, compared to only 33% last year. This increase has occurred across all age groups, but in particular amongst those aged under 65. Compared to women, men are more likely to be abused by paid carers, and less likely by family and friends. Where they are abused by family friends this is more likely to be a friend or neighbour. (13.5% compared to 5% of women)

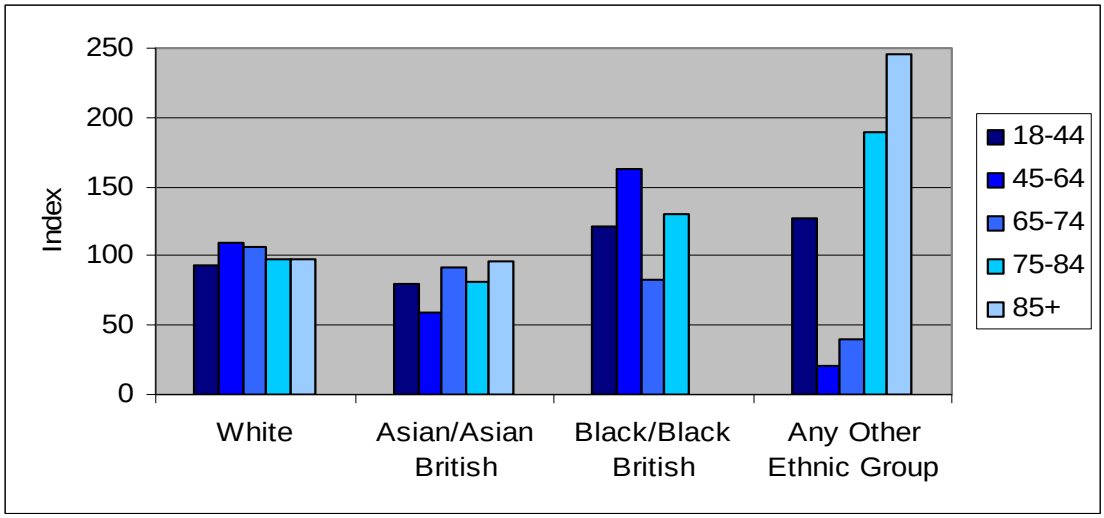
## 13.4 Ethnicity

Ethnicity was recorded for 523 of 534 vulnerable adults. Of these 523 adults, 73% were from a White ethnic background, 9.4 % were from an Asian background, 9.4% from a Black background, and the remaining 7.6% were from other ethnic groups, including Chinese and Middle Eastern groupings.

Despite the numbers increasing from last year, the proportion of alerts involving white adults dropped significantly from 80% to 73 %. The number of cases involving Black/Black British adults has increased by more than 50% and the number of cases involving adults from Chinese and any other ethnic group more than doubled.

| Ethnic grouping | 2008/09 | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|
| White | 282 | 313 | 379 | 385 |
| Asian / Asian British | 21 | 34 | 46 | 49 |
| Black / Black British | 17 | 29 | 32 | 49 |
| Any Other Ethnic Group | 23 | 24 | 18 | 40 |
| Ethnicity not known | 2 | 20 | 21 | 11 |

The chart below shows how the 2011/12 case list compares to the 2012 population estimates for Barnet: an index of 100 means that the case list is perfectly representative within that age group; a lower index means that there are fewer safeguarding cases from that ethnic group than we would expect; and a high index means there are higher than expected cases from that particular ethnic group.




The figures show that cases involving White adults make up roughly the proportion that we would expect; there are fewer cases involving Asian adults, and there are generally more cases than we would expect involving Black adults (particularly younger adults) and adults from other ethnic groups (in this case those aged 75+).

## 13.5 Funding Arrangements

In 2011/12, there were 55 safeguarding cases involving people who fund their own care and 77 cases involving adults who were receiving no services. Unsurprisingly, abuse by friends and family featured heavily in those cases where no service was being provided; and in services that were self-funded, a slightly higher proportion involved abuse by a paid carer compared to instances where a Barnet-commissioned service was being provided.

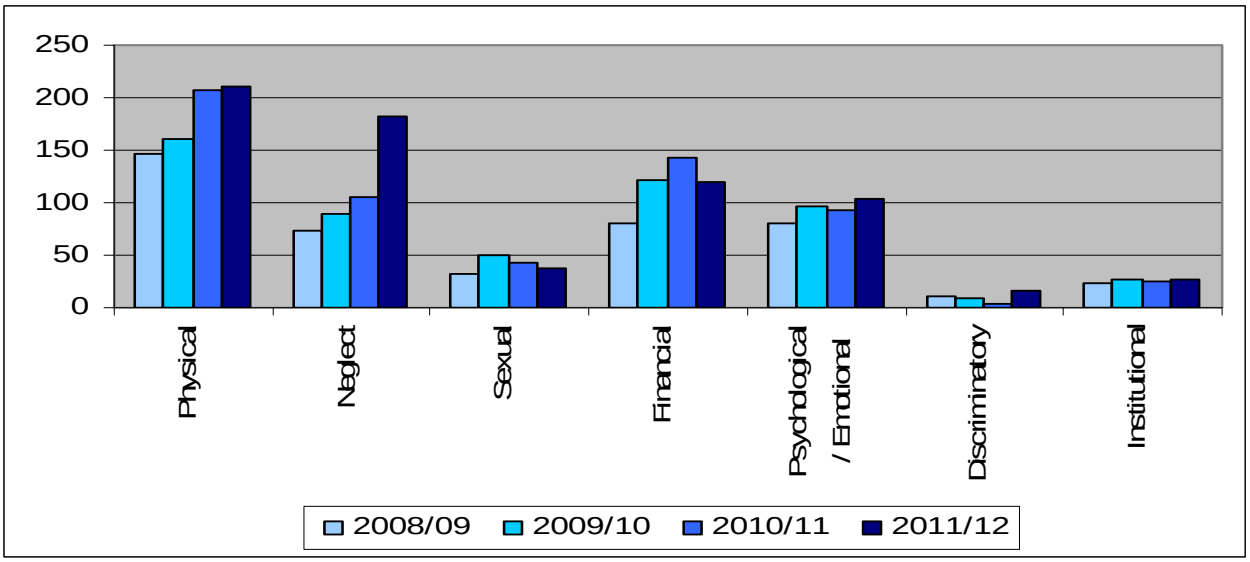
| | Number of referrals | % involving friend or relative | % involving paid carer |
|---|---|---|---|
| A Barnet-commissioned service | 313 | 24% | 41% |
| A service funded by health | 43 | 40% | 30% |
| A self-funded service | 55 | 35% | 45% |
| Service commissioned by another council | 46 | 7% | 67% |
| No service | 77 | 73% | 4% |
| Combination of funding authorities | 5 | 20% | 40% |
| Missing data | 1 | 100% | 0% |

All but one of the 55 people who fund their own care was an older person, with half of the alleged abuse occurring in a care home setting. Of those receiving no service, 56% were older people and a further 29% were adults with mental health needs. In nearly two thirds of the 77 cases involving people receiving no service the person who caused the alleged harm was a friend or relative in the adult's own home.

Only 29 adults involved in safeguarding alerts in 20111/12 were recorded as having a personal budget, although it is unknown whether this is delivered via a direct payment or via a managed budget.

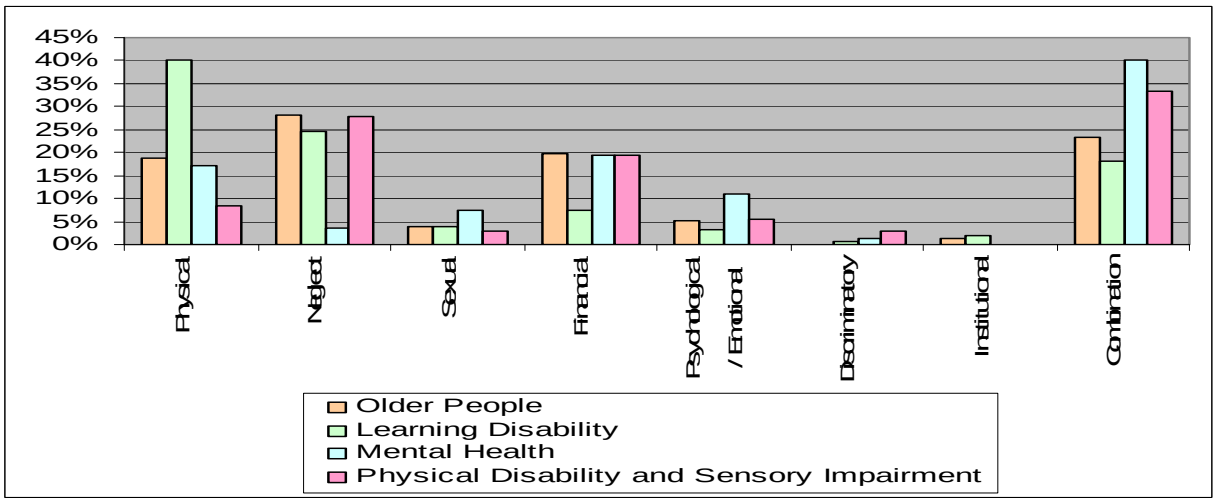
## 13.6 Type of abuse

This year has seen a slight increase in the number of alerts concerning physical abuse, institutional abuse and psychological abuse, and the numbers of alerts concerning sexual and financial have dropped slightly. However there has been a significant increase in the numbers of alerts involving neglect, with numbers increasing by over 70%. This includes allegations where neglect was reported along-side other types of abuse.




When comparing the relationship between the needs of the adult at risk and the type of abuse the following patterns emerge:-

- Older people are more at risk of neglect (37%) & financial abuse (26%).
- Adults with learning disabilities are more at risk of physical abuse (49%) and neglect (30%)
- Adults with mental health problems are more at risk of financial abuse (32%) and physical abuse (28%),
- Adults with physical disabilities are more at risk of neglect (44%) and financial abuse (28%)

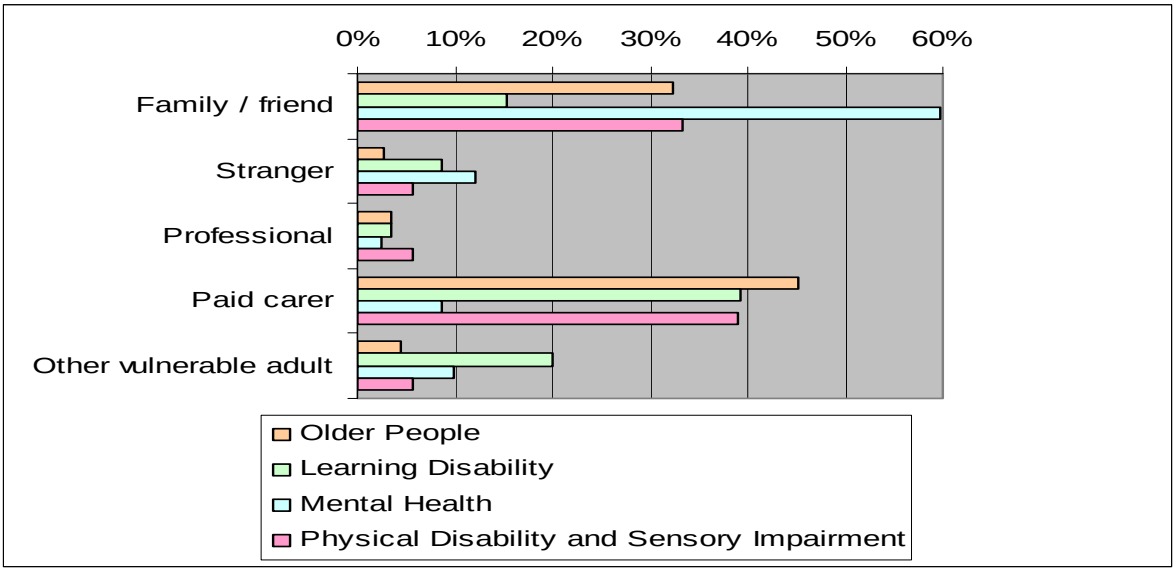


## 13.7 Person who caused the harm

2011/12 saw similar patterns to previous years when identifying the person who caused the harm. Paid carers were the largest group reported (37%), followed by friend/relative (32%)

| Person who caused the harm | 2008/09 | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|
| Friend / Relative | 39% | 41% | 37% | 32% |
| Paid Carer | 47% | 32% | 30% | 37% |
| Other vulnerable adult | 8% | 7% | 8% | 10% |
| Stranger | 5% | 6% | 3% | 6% |
| Professional | 1% | 2% | 3% | 3% |
| Not Known | - | 5% | 17% | 9% |
| Other | - | 7% | 2% | 3% |
| | | | | |

The chart below compares the different client groups by their relationship to the person who caused the harm. Adults with mental health problems are more likely to report abuse by family and friends, where as adults with learning disabilities more commonly report allegations relating to other vulnerable adults.




## 13.8 Paid Carers

2011/12 saw a large increase in the numbers and proportion of alleged abuse by paid carers. As shown in the table below, the number of cases increased for all providers except self-directed staff, and there was a significant leap in the number of cases involving nursing care homes. Around half of the alleged abuse by paid carers involved neglect, with higher numbers in care home settings.

| | 2010/11 | 2011/12 |
|---|---|---|
| Residential care | 53 | 63 |
| Nursing care | 37 | 62 |
| Domiciliary care | 29 | 35 |
| Day care | 6 | 14 |
| Self-directed staff | 2 | 0 |
| Other | 20 | 27 |
| **Total paid carers** | **147** | **201** |

These 201 alerts encompass a long list of different care providers. Most providers appear only once, however, there are 27 providers who feature more than three alerts within the year.

**Grade 3-4 pressure ulcers** were reported as a possible indicator of neglect in 61 cases (11%) 38 of these occurred in a care home setting, mainly nursing care. In 5 nursing homes this issue was reported more than three times within the year. The remaining 15 were acquired in the vulnerable adult's own home, where care was received by a paid carer, friend or relative.

### 13.9 Friends and Family

In 2011/12 there were 173 alerts where a relative or friend was alleged responsible for the harm. The profile of people who cause the harm was similar to last year, with harm by friends and neighbours, partners and sons and daughters accounting for 79% of alerts.

| | 2010/11 | 2011/12 |
|---|---|---|
| Partner | 48 | 44 |
| Parent | 15 | 12 |
| Friend / neighbour | 53 | 47 |
| Son / daughter | 42 | 46 |
| Other relative | 21 | 24 |
| Volunteer | 3 | 0 |

***The person who caused the harm was reported to be the main carer in only 39 of these 173 cases***

### 13.10 Alerts leading to investigation

We have been working hard to raise awareness of abuse, and we want people to tell us if they are concerned that someone is at risk. Not all alerts will turn out to be abusive situations, they could be about a need for services or other help. Of the 540 cases alerted **448 (83%) were investigated**. In the other 92 cases (17 %) we carried out an assessment of need, or referred onto another more appropriate agency to help. For those cases which did progress, we responded quickly within the national standards. In 48 cases it was decided with was no initial action taken beyond discussion with relevant agencies, with over three quarters of these cases involving older people.

### 13.11 Safeguarding Outcomes

For every case investigated we decide if we think the abuse happened (substantiated), or where there was more than one type abuse reported and we think that part happened ( partly substantiated) did not happen (not substantiated) or it is not possible to say (not determined).

382 cases have now been completed and an outcome determined. The table below reports the outcomes of these cases and compares them to the outcomes of cases reported in

2010/11. At the time of writing this report 66 cases remain open and case outcome is not yet determined.

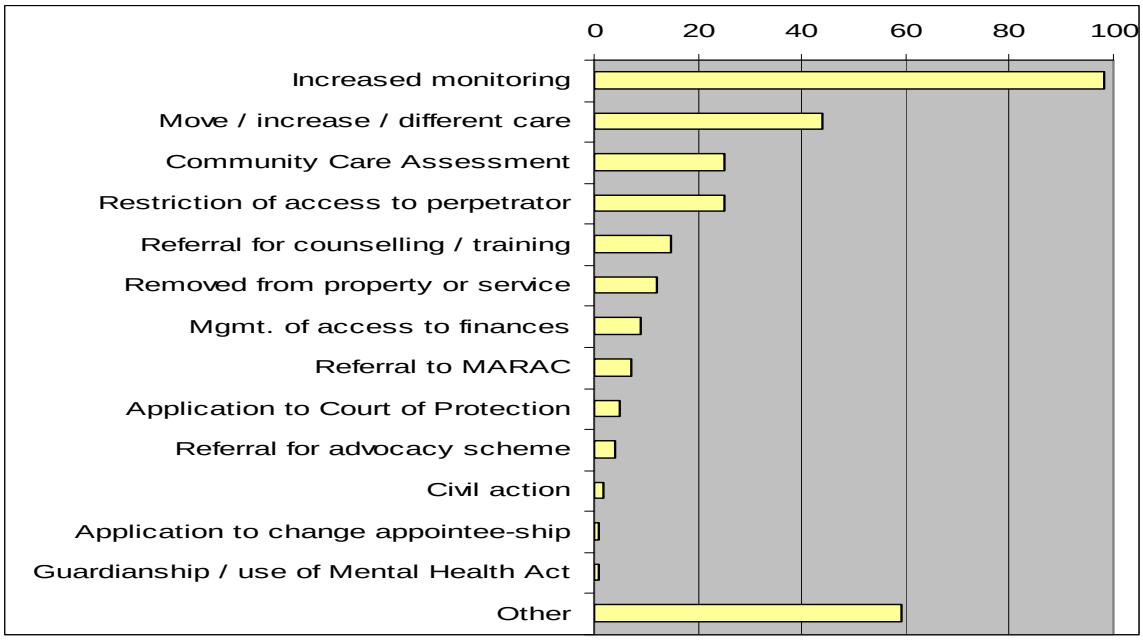
| | Number of Cases 2010/11 | Percentage of Cases 2010/11 | Number of Cases 2011/12 | Percentage of Cases 2011/12 |
|---|---|---|---|---|
| Abuse substantiated | 129 | 36% | 148 | 39% |
| Abuse partly substantiated | 48 | 13% | 40 | 10% |
| Abuse not substantiated | 98 | 27% | 102 | 27% |
| Not determined / Inconclusive | 88 | 24% | 92 | 24% |

Of the 102 cases which were not substantiated, 59% involved older people and 24% adults with learning disabilities. The majority of unsubstantiated cases were allegations against paid carers particularly staff who worked in a care home setting.

In those cases where the evidence was deemed to be inconclusive, friends and family are more likely to be involved than paid carers. There appears to be particular issues around gathering substantive evidence relating to sexual and financial abuses.

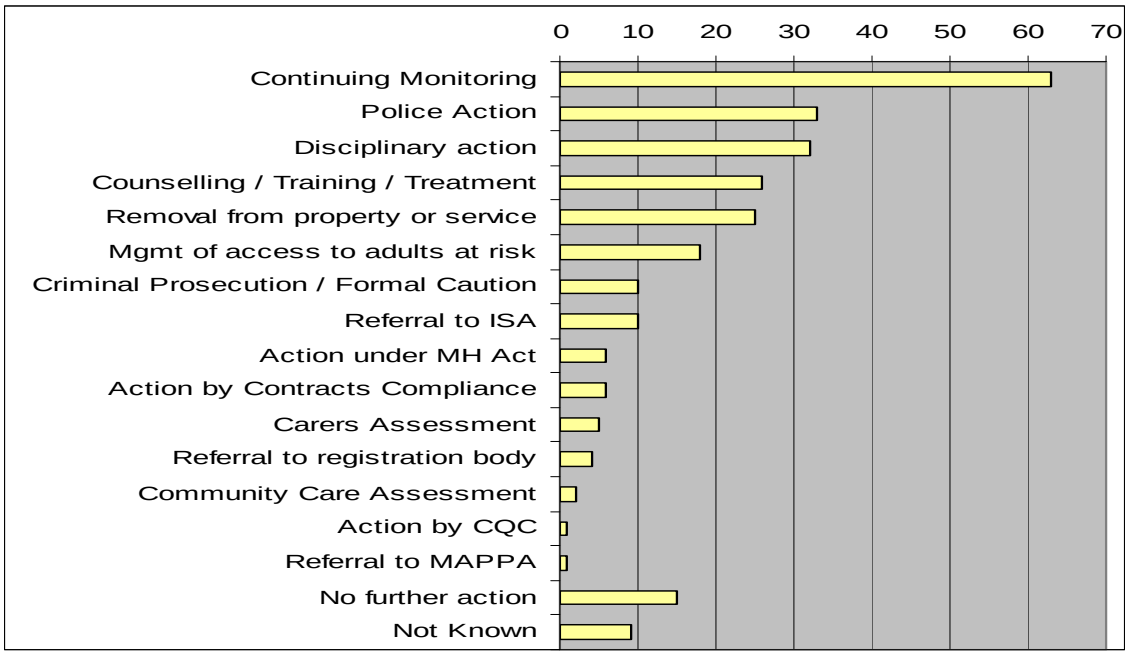
### 13.12 Action taken to help the adult at risk

In all safeguarding investigations we try to help the adult at risk stay safe from harm. The chart below shows what help we gave people where abuse took place. In most cases we increased monitoring of the situation. This means we might visit the adult more often or ask those involved in the person care to regularly let us know how they are. We also put in place different things to help adults at risk stay safe in the future.



### 13.13 Action taken in relation to the person who caused the harm

The chart below shows what action was taken in relation to the person who caused the harm. In most cases monitoring was also the most likely action taken, although police action, disciplinary action, counselling, training or treatment and removal from property or service were also common responses. Only in a small number of cases no further action was taken.




## 14 Safeguarding Stories

Below are three real stories about Barnet residents who use services. We have changed all the details that might identify these people, but the stories are true.

*Mr Lawrence has had three previous fires in his accommodation. He is a heavy drinker, a heavy smoker and has is unable to walk very far due to a disability. He is at high risk of having further fires.*

*Staff at Barnet Homes and the London Fire Brigade worked closely together to provide him with fire retardant bedding, a new bed and sofa and fitted a domestic sprinkler system to help keep him safe. This is the first domestic sprinkler system to be fitted in Barnet. Mr Lawrence is very grateful for their work to keep him safe.*

*Mr James, a man with mental health problems, told his Care Co-ordinator that a woman had been asking him to give her money and he had been giving the money to her. He stated that he was unable to say 'no' to her and thinks he might have handed over up to £1000. He was unable to confirm the exact amount he had given.*

*The Care Co-ordinator made a safeguarding referral, and made arrangements to ensure Mr James' money was safe while an investigation took place. It was found, on viewing bank statements that, during a two month period, a significant amount of money was withdrawn from Mr James' post office account. It was also found that at present Mr James needed much more help to manage his money.*

*In this case the police were unable to investigate further because they were unable to get enough information. However a meeting was held to plan for Mr James' protection. He agreed to more help to manage his finances. Since these plans have been put in place Mr James reports that the woman has not approached him to ask for money, and that he feels more able to say 'no'.*

*Adult Social Services received a telephone call to say that the care in a care home was not good enough, that residents were treated badly and that staff were not properly checked or trained.*

*The Social Work Manager spoke to the inspector from the Care Quality Commission and Barnet's Contracts Manager and together they did an unannounced visit to the home. They checked all the homes records, and spoke to residents and staff and other people who visit the home, like relatives and district nurses. They also watched the staff at work.*

*They found that the home was doing some things well, but that there were lots of things that needed to be much better. The home manager was told that her records in the home needed to improve to make sure they captured resident's needs, that her staff needed some specialist training and supervision and that the food needed to improve. The manager was told to do these things within a certain time, and the Social Work Manager went back to check these things were done.*

*The home is now doing well. The manager has worked hard to listen to the views of residents and relatives in the home so that everyone is happy with the care. She has also introduced an advocate to the home so residents and relatives can speak to an independent person if they wish.*

## 15 Next Steps

### The next steps for the Safeguarding Adults Board are:

- Find out the views of adults at risk who have experienced safeguarding services to test whether we have helped to make them safer
- Ensure people have access to information and advice about protecting themselves, and what to do if they are being harmed or abused.
- Ensure GP's know how to report abuse and their role in safeguarding adults procedures
- Ensure people with mental health problems who use drugs or alcohol have access to safeguarding services
- Ensure everyone knows how to report disability hate crime, and that once it is report it is investigated
- Ensure there is training to make sure everyone knows how to safeguard adults at risk
- Make sure all staff knows about the Mental Capacity Act and the use of Independent Mental Capacity Advocates role in safeguarding work.
- Work to prevent people getting pressure ulcers and investigate what happened when they are a sign of neglect.
- Ensure all partners have plans to check that people who use services are treated with dignity and respect.
- Ensure partners who commissions services for vulnerable adults have plans to check that the quality of care good.
- Review a case where there was a death of a Barnet resident to find out if there are any lessons to be learnt about the way the partnership work together to safeguard vulnerable people who refuse care.
- Act on the recommendations of the domestic homicide review to ensure lessons are learnt.

## Appendix 1: Annual Statements 2012

## Organisation: Barnet Borough Police

**Internal arrangements for governance regarding safeguarding adults at risk**

- The Metropolitan Police Service (MPS) has a specific policy and standard operating procedure for Safeguarding Adults; awareness of which is delivered, through training, to all operational staff.
- Barnet Police has a Detective Chief Inspector lead for Public Protection matters which incorporates Safeguarding, along with a dedicated Detective Sergeant for Safeguarding Adults.
- Existence of a Police Community Safety Unit (CSU) which is dedicated to the investigation of all hate, domestic violence and adult safeguarding crime.
- All CSU staff undertake a specific two-week course to be able to understand and effectively investigate the above crimes
- Representation on the Adult Safeguarding Board through attendance of a senior police leader (minimum Detective Superintendent level)
- Daily Management meetings, chaired by a member of the Senior Leadership Team, where risk and harm for all crime is assessed and appropriate resources allocated.

**Work undertaken and achievements in 2011/2012**

- The Borough has achieved excellent detection rates for all hate crimes (homophobic, racial and domestic), exceeding all the targets set for this performance year.
- Provided resources to the tri-borough Mental Health Assessment Team (Haringey, Barnet & Enfield), supporting problem solving activity and interventions with communities.
- Created a streamlined referral process via a safeguarding mailbox, to prevent loss of information and to ensure early intervention on high risks cases.
- We have also supported the multi-agency homicide review processes, designed to capture learning and improve our ability to prevent serious crimes of violence.
- Developed plans with partners on the creation of a Multi-Agency Safeguarding Hub (MASH) to ensure a more dynamic and holistic approach to safeguarding victims.

**Work Planned for 2012/2013**

- An MPS wide review has been completed and it is now intended to implement a new local policing model, with the aim of improving performance, public satisfaction, and enhancing capability, particularly in respect to crimes of violence and risk.
- Implementation of MASH to ensure timely risk assessment and action in relation to vulnerable children and adults across the partnership.
- Continuing to provide information, support and resources into the development of an intervention project, which intends to concentrate partnership resources on those families with the most complex needs across all agencies.
- Working with partners to implement a co-located Integrated Offender Management Unit, allowing a more joined up and speedy response to offender's risks and needs.

**Mark Strugnell**
**Detective Superintendent, Head of Crime Investigation**

## Organisation: Barnet Enfield and Haringey Mental Health Trust and Enfield Community Services

**Internal arrangements for governance regarding Safeguarding adults:**

- The Trust has a Board Lead for Safeguarding Adults, the Director of Nursing, Quality and Safety.
- The Trust has an Assistant Director for Safeguarding Adults who is the corporate lead for safeguarding adults in the Trust
- As part of the governance structure in Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) and Enfield Community Services (ECS) the Safeguarding Adult Committee continues to meet on a bi-monthly basis. This meeting affords for the discussion and follow up on actions from both internal and external issues regarding safeguarding adults
- A safeguarding annual report continues to be developed on a yearly basis for presentation at the Trust Board. This year's annual report will be presented to the Board in May 2012.
- The Assistant Director for Safeguarding Adults continues to represent the Trust at the three Safeguarding Adults Boards.

**Work undertaken/planned and achievements/progress in 2011/2012:**

- During 2011/12 there was a continued drive to ensure that people who use services in BEHMHT are safeguarded from abuse and any reported abuse was dealt with as per the Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse" (Pan-London Procedures).
- A service user booklet has been developed which give service users written information about abuse and how to report abuse. The booklet was distributed to all wards and teams.
- A Trust self-assessment was carried out by the AD for Safeguarding Adults using the Safeguarding Adult Assurance Framework for Healthcare Services. This allowed for a benchmark against the given standards in the Framework. The actions from the assessment have been taken forward by the AD Safeguarding adults.
- A balanced scorecard have been developed which will be used to report of safeguarding activity to the Trust Board. It is planned that a report will be presented three times per year
- Bespoke Safeguarding Adult Training has been delivered by the AD Safeguarding Adults to staff within the wards in the Dementia and Cognitive impairment Service Line. This training was undertaken as part of the actions and learning lessons from a Safeguarding investigation.
- A safeguarding adult audit tool has been developed and is now on Meridian. The tool will enable Team Managers to audit one safeguarding case per month.
- The Trust Level 1 training slides has been updated to include the changes as set out in the pan London procedures
- Following a Fire Death Review in Barnet the Fire Brigade have developed a referral form to be used by partner agencies. This form is to allow partner agencies to make referrals for home safety checks for those service users who are a known fire risk due to being a smoker or other fire risk factors. The referral form has been circulated to all Team Managers.

- The Trust has been carrying out compliance inspections against the criteria in Outcome 7 (safeguarding) of the CQC's new regulatory framework on all inpatient units and Community Teams.
- Case File Audits have been carried out as part of a quality assurance measure
- 1761 staff attended level 1 safeguarding adult training during 2011/12.This training is offered as part of the mandatory training day.

**Work planned for 2012/2013:**

- The Trust will incorporate the following elements into its SOVA programme for 2012/13:
- Ensure that a planned programme of Bespoke Safeguarding Adult training is undertaken and delivered to Managers and staff in the Forensic service.
- Ensure that training in Domestic violence is delivered to staff in BEHMHT to raise awareness and gain further understanding of the referral process.
- As part of a quality measure Team Managers to audit 1 case file per month on Meridian. By doing this Managers will get instant results of the audit.
- Maintenance of the Trust wide Safeguarding Adult Database
- Review of the Trust self-assessment using the Safeguarding Adult Assurance Framework for Healthcare Services.
- To get regular reports from the Datix Manager to enable for the tracking of incidences on Datix that has been reported as a safeguarding case.
- Further develop closer working with the Serious Incident and Complaints Manager to ensure the continued integration of the three processes at the time an incident happens.
- A planned programme of compliance inspections against the criteria in Outcome 7 of the CQC regulatory Framework to be carried out by the Practice Standards Leads.
- As part of the implementation the Bournemouth Competency Tool to ensure that the Trust has a system that gives consistency in the use of the tool.
- Continue to deliver level 1 safeguarding adult training as part of the mandatory training day.

**Veronica Flood**
**Assistant Director Safeguarding Adults**

## Organisation: Carers' Support Organisations Network

**Internal arrangements for governance regarding safeguarding adults at risk**

- The Network of Carers' Support Organisations is one of a number of network groups supported by Community Barnet and is made up of 18 voluntary organisations.
- It meets every three months, to coordinate and improve the support for family carers. These carers' support organisations provide services for those caring for older people, people with learning disabilities, disabled people and people with mental health needs, or health conditions.
- The representative on the Safeguarding Adults Board is elected by the members and reports to the Network.

**Work undertaken and achievements in 2011/2012**

- The main aim of the work undertaken in 2011-12 has been to raise awareness of safeguarding issues for staff and volunteers in carers' support organisations. The launch of the pan-London guidelines, Protecting Adults at Risk, has been an opportunity to highlight the changes in policy and practice. It has meant we could re-visit the importance of safeguarding. We have been able to stress the role staff and volunteers can play in identifying and investigating abuse and the crucial role carers' support organisations have in preventing abuse.
- There have been presentations on the pan-London guidelines at the Learning Disability and Mental Health Networks and at the Carers' Partnership Board, where safeguarding is now a standing item on the agenda.
- Safeguarding increasingly has a high profile for family carers themselves. The Winterbourne scandal in May encouraged discussion at the Parents Action Group and helped prompt a report and presentation at the SAB about placements for people with learning disabilities. Family carers attended an Awareness session in November, which was very successful, and more are planned by the Carers' Centre for the coming year. Carers also contributed to the consultation on the Care Quality Commission Judgement Framework.

**Work Planned for 2012/2013**

We have not been able to achieve all of the goals set for 2011-12. The work plan for the coming year needs to build on the successful initiatives and to address the gaps.

1. From May 2012 the new carers' support contract will have been awarded and this will have a significant impact on the way carers are provided with advice, information, practical and emotional support and short breaks. Carers support should be more focused and better co-ordinated but funding will be reduced. We hope to see an increase in carers' assessments and clearer recording of carers' support needs. Information on safeguarding – and any gaps – should be available and better targeted.

2. Carers continue to have concerns about the quality of care in residential homes and supported living projects. Work is underway to involve carers in the work of LINKs and in their Enter and View programme. More needs to be done to publicise the role and

responsibility of the CQC and how it links with bodies such as the Local Government Ombudsman, or whistle-blowers.

3. Carers and the organisations that support them still need to know more about the Mental Capacity Act.

4. There is a need for better analysis of the monitoring data, so that we have a clearer picture of the role of family carers in safeguarding. This could be as 'people who abuse', in raising alerts, or where there is inter-personal abuse between family carers and the person they care for, and the links with domestic violence.

5. More work will be done this year to raise awareness of Hate Crime against disabled people. We need to involve carers' organisations and statutory bodies in this and to include a focus on tackling hate crime where people live with carers at home.

6. The Carers' Forum will be re-launched. This should help to strengthen the links between carers and the staff in voluntary and statutory organisations who support them.

**Ray Booth**
**Chief Executive, Barnet Mencap**

## Organisation: London Fire Brigade

**Internal arrangements for governance regarding safeguarding adults at risk**

- London Fire Brigade (LFB) has a policy specifically for Safeguarding Adults which is known by all fire officers.
- If an officer suspects there may be a safeguarding issue, details are forwarded to the duty Assistant Commissioner who will decide whether to make a referral to the Local Authority or not.

**Work undertaken and achievements in 2011/2012**

- LFB has started a new partnership arrangement with Barnet's Domestic Violence Sanctuary Scheme. The partnership ensures that a Home Fire Safety Visit is carried out to all women on the scheme. The LFB will also provide an arson-proof letter box when deemed necessary.
- LFB has also embarked on new partnerships with Barnet Civil Service Retired Members and the Barnet Elderly Asian Group. These partnerships provide LFB with referrals for Home Fire Safety Visits for vulnerable members of the community.
- LFB within Barnet have established a more robust system to identify premises in the borough that have had more than one fire in the home over the past two years. If premises are identified, LFB staff ensures that a Home Fire Safety Visit has been provided and that all appropriate measures have been considered to prevent further fires occurring. This includes liaison with other agencies including Barnet Social Services.
- LFB have successfully persuaded Barnet Homes to provide a domestic sprinkler system for an individual known to be at high risk from having further fires. (He has had 3 previous fires, is a heavy smoker, heavy drinker and has severe mobility issues). This is the first domestic sprinkler system to be installed in a private or rented home within Barnet (as far as we know).

**Work Planned for 2012/2013**

- Continued working with the Adult Safeguarding Board, seizing opportunities to make vulnerable people safer.
- Continued working with all identified partners, improving links when necessary to make vulnerable people safer.
- LFB will carry out over 2500 Home Fire Safety Visits within Barnet during 2012/13; the vast majority of these will be to vulnerable people or within areas that we have identified as being at higher risk of fire.
- LFB will introduce a Functional Working model across its stations in North West London. Under this model the Borough Commander and 1 Station Manager will work solely on Community Safety and partnership work within Barnet. This enhancement has the potential to see an improved service including the introduction of a more robust quality assurance process.

**Tom George**
**Borough Commander, Barnet**

## Organisation: Barnet Homes

**Internal arrangements for governance regarding Safeguarding adults**

- Lead Officer and Board member for safeguarding adults is Gladys Mhone, Head of Human Resources of Barnet Homes, with the deputising role being undertaken by Dorothy Tucker, Sheltered Housing Project Coordinator.
- This arrangement will ensure an appropriate level of seniority and leadership. By combining non frontline officer with a practitioner with knowledge and experience as deputy we will be able to contribute better to driving Safeguarding culture, skill and knowledge across the organisation
- Our Business Plan aims to have a clear understanding of our residents, including their needs and priorities. This aim will ensure that our vulnerable adults are known that their needs identified and targeted to improved their lives.

**Work undertaken and achievements in 2011/2012**

- Board Training was carried out and a paper to update Board on Safeguarding activities was presented at the June Board Meeting
- Communicated the Pan London Safeguarding Procedures from September 2011
- We set up a Barnet Homes Safeguarding Internal working group to ensure that staff champion safeguarding issues within their areas of work and improve our working relationship with Social Services by inviting them to meeting and Barnet Homes staff attending their meeting.
- We commissioned in-house training for staff who may have missed previous year's training on Safeguarding
- We focussed on financial abuse as a theme in response to cases that were reported
- We have continued to seek feedback from the working group to understand priorities that require focusing on and any improvements in raising safeguarding awareness
- CM - safeguarding item has been created on CM to log any safeguarding actions (referrals/calls) for monitoring purposes

**Work planned for 2012/2013**

- We will carry out regular articles in the staff newsletter (quarterly) to ensure people understand that safeguarding is everyone's responsibility
- We will continue to work loosely working with Social Services – Service Manager attending Barnet Homes meeting and Barnet Homes attending Social Services meetings and urgent allocation meetings
- We will design Referral form to social services for tenants needing support that does not involve safeguarding
- We will establish connections with Mental Health Services
- We will participate in World Elder Abuse Awareness Day 15 June 2012 (Suggestion for sheltered housing schemes to organise activity/discussions around "keeping safe at home" and invite police fire service with help from our Health and Safety Department
- We will carry out a Lunch & Learn presentation in November 2012

**Gladys Mhone**
**Head of Human Resources**

## Organisation: Royal Free Hampstead NHS Trust

**Internal arrangements for governance regarding Safeguarding adults**

- The Trusts Adult Safeguarding Policy was updated to bring it in line with the Pan London Multi Agency Adult Safeguarding Policy.
- In line with the requirements for regulation by the Care Quality Commission the trust has developed and ratified a Gifts Policy
- The Trusts internal Safeguarding Adults Board continues to oversee all adult safeguarding issues related to the Trust
- There has been no change in staff members of the Adult Safeguarding Team
- In external audit of safeguarding was carried out by KPMG last year. They highlighted areas of good practice such as good self assessment processes, highly knowledgeable experts and good staff awareness. They also made 3 recommendations: -
    1. Update training to support staff in their roles when talking to patients about safeguarding issues
    2. Training to include information on gaining feedback from alerts
    3. Completion of mandatory training should be part of performance objectives with clear consequences for none completion.
- All the recommendations have been implemented.
- The Trust attained Foundation status in March 2012 and as such will in the future receive additional scrutiny from MONITOR (the regulator for Foundation Trust) in addition to the regulation by CQC

**Internal arrangements for training regarding Safeguarding adults**

- The new training programme incorporating adult protection, child protection and the Mental Capacity Act (MCA) level 2 that was launched last year has been evaluated with very positive results.
- In September 2011 the level 2 programme was updated as a result of the evaluation.
- Level 1 training continues to run at staff induction but in addition to this in February 2012 all staff at RFH received update information for adult safeguarding in a leaflet that accompanied their payslip
- In a bid to open up alternative opportunities to staff to attend training level 2 sessions have been run out of normal working hours in the evenings and on weekends.
- Level 3 safeguarding workshops for senior staff continue to be delivered by Middlesex University, with input from clinical experts.

**Work undertaken and achievements in 2010/2011**

- The number of referrals from the Royal Free Trust to the Camden Independent Mental Capacity Act Advocate (IMCA) service has continued to grow and in the last year 50% more referrals were made than in the previous year
- A successful bid for funding was made during the year with an award of £5,700 being made by Camden Adult and Social Care Services for the Trust to provide MCA training to staff.
- A total of thirteen Deprivation of Liberty requests have been made since April 2011. However due to a change in direction taken at the Court of Protection during this period namely with the Cheshire West case but also with other similar cases less

issues in health care are being deemed a deprivation of liberty hence it is anticipated that fewer DOLS applications will be required in the coming year.

- A 149 adult safeguarding cases were formally referred to adult social services across the UK during the last year, a 50% increase from last year.
- An audit of all clinical incidents was completed in February 2011 to review the compliance with processes of escalation to adult safeguarding. The audit found that all cases with an adult protection element had been escalated appropriately.

**Work planned for 2011/2012**

- Continued efforts to increase training uptake and raise awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards will be ongoing, including offering out of hours training options to staff.
- The Organisational Development and Learning Department are investigating the option of to supplement the trainng options by the provision of an e-learning package for level 2 training.
- The Trust's internal Adult Safeguarding Board is working with public health colleagues to develop 2 new policies regarding domestic abuse. One will be about Trust staff who could either be suffering domestic abuse or perpetrating domestic abuse and the other policy will relate to responding to patients who are subject to domestic abuse.

**Linda Davies**
**Safeguarding Adults Operational Lead**

## Organisation: Barnet and Chase Farm Hospitals NHS Trust

**Internal arrangements for governance regarding Safeguarding adults:**

- The Director of Nursing is the Director responsible for Safeguarding.
- One of the Deputy Director of Nursing acts as the corporate lead for Vulnerable Adults.
- A Medical Matron on each site act as operational leads, providing advice and support to staff on adult protection policies and procedures
- The Trust has a vulnerable adult's board which meets quarterly and has a safeguarding strategy group to ensure that learning from both children's and adults safeguarding are taken forward within the organisation.
- An Annual Report which includes the Annual Reports from both the London Borough of Barnet and London Borough of Enfield is taken to the Trust Board.
- A quarterly report which includes the number of safeguarding alerts/investigation and the numbers of staff who have attended safeguarding training is taken to the Quality and Safety Committee

**Internal arrangements for training regarding Safeguarding adults:**

- There is a session on induction for all staff.
- Additional training has been provided by an external trainer.
- The Trust is promoting e-learning for all statutory and mandatory training and has e-learning packages on Safeguarding, Mental Capacity Act, Deprivation of Liberty Standards and Dementia
- 1067 staff attended safeguarding training in 2011/12 (February 2012)
- Medical Staff have an e-learning package as part of induction and 271 medical staff have completed the e-learning package
- The Trust solicitor provides training on the mental capacity act.
- Additional training has been provided on the Deprivation of Liberty Standards
- Training has been provided on caring for patients with dementia in an acute setting as part of the Trusts Dementia strategy.
- Additional training on dementia has been provided as part of the launch of the Butterfly Scheme
- SOLACE has provided training on Domestic Violence for the Trust.

**Work undertaken/planned and achievements/progress in 2011/2012:**

- The Trust has revised its Safeguarding Adults at Risk Guidelines following the publication of the Pan London Protecting Adults at Risk Policy. The Guidance includes a flow chart for alerting and investigating abuse
- As part of safeguarding awareness week and Nurses day the Trust had information stalls on both sites.
- The "We Care" campaign has introduced the Quality of Interaction Observational Tool (QUIS) to improve the quality of interaction and communication between staff and patients.
- QUIS audits are undertaken monthly and staff is using this tool to reflect on how they care and to agree actions as a team to continue to improve care and communication. The results of the QUIS audits are reported on as part of performance review

- The Trust is making environmental changes within the ward areas to improve the facilities for patients with dementia this includes the use of symbols and colours to identify key areas within the wards
- The Trust continues its ongoing commitment to reducing the inequalities experienced by people with learning disabilities when accessing health care environments.
- Training in Learning Disability awareness is provided in a number of formal and informal sessions
- The Acute Liaison Nurse has provided training to specific wards and departments and has supported the Day Surgery Unit to identify reasonable adjustments they can make to their pathways
- Visits to the hospital for people with learning disabilities are ongoing and there have been a number of tours of the diagnostic imaging (x-ray) department, surgical wards, day surgery and theatres. The ALN also provides support for individual clients who have outpatient's appointments or planned admission. This may include tours of the departments, meeting the staff, looking at the equipment and advance planning for the reasonable adjustments that may be required.
- The Acute Liaison Nurse for patients with a learning disability undertakes sessions on recognizing the needs of people with a learning disability as part of the student nurse induction.
- The Trust has re-vamped its Safeguarding pages on the intranet and has a combined safeguarding page for children and adults with signposts to relevant sections.
- The Trust implemented the dementia pathway and as part of its dementia strategy. As part of this a range of information and advice sheets are available to patients, staff and their relatives.
- The Trust has implemented 'green cup' scheme for patients with dementia to prevent dehydration.
- Distraction boxes have been implemented for patients with dementia
- The Trust has implemented a 'carers badge' scheme.

**Work planned for 2012/2013:**

- As part of Nurses Day the Trust intends to hold safeguarding awareness stalls.
- The Trust is planning further environmental changes as part of its dementia strategy, and extending the use of colour and symbols to identify specific areas
- The Trust intends to continue hosting 'Demystifying Hospital' visits for patients with learning disabilities'.
- The Trust has commissioned further training on caring for patients with dementia in an acute setting
- The Learning Disability Liaison Nurse will continue to work with the communications department to develop patient information leaflets in an accessible form.
- The ALN is also looking at ways our cancer services and preadmission clinics can be improved to take into consideration the unique needs of some of our patients with learning disabilities
- The Trusts Patient and Relatives Group will launch their carers strategy during nurses week.

**Teresa McHugh**
**Deputy Director of Nursing**

## Organisation: Community Safety, London Borough of Barnet

**Work undertaken and achievements in 2011/2012**

2011/12 was a year of transition within Community Safety which has seen the responsibility for drugs and alcohol transfer to Adult Social Services as part of the development of the Public Health Agenda and also the transfer of Domestic Violence to Children's Service to build upon the approach of early intervention and prevention. In addition to the successful transfer of responsibilities the following was achieved in 2011/12:

- A revised governance process for anti-social behaviour (ASB) case management was implemented where cases are now referred to a multi agency fortnightly intelligence meeting hosted by the Police. This included ensuring referral pathways are clearly signposted to all relevant agencies and departments. In addition a standard risk assessment process for ASB cases was agreed and implemented with partners which includes a clear focus on safeguarding and vulnerability criteria.
- Priority Intervention Officers received safeguarding training in February 2012
- Co-ordination with an Adults safeguarding event led by MENCAP in February 2012 with a particular focus on Hate Crime
- Hate Crime third party reporting sites refreshed
- Delivery of an underage sales programme

**Work Planned for 2012/2013**

- Focus on repeat victims of ASB and development of a multi agency ASB risk assessment conference
- Focus on identifying repeat perpetrators of ASB and integration with early intervention and prevention pathways
- Work with Registered Social Landlords to develop information sharing and standardise the risk assessment process for ASB
- Delivery of Safeguarding training to newly formed Integrated Offender Management (IOM) Team
- Development of a joint safeguarding protocol between Adults and IOM
- Annual review of third party reporting sites
- Development of a co-ordinated Community Safety communication plan
- Implementation of Hate Crime action plan
- Delivery of an underage sales programme

**Paul Lamb**
**Community Protection Group Manager**

## Organisation: Central London Community Healthcare NHS Trust - Barnet

**Introduction**

- Central London Community Healthcare NHS Trust(CLCH) -Barnet –continued to meet regularly over the course of the past year with representatives from all the Operational services in Barnet

- In December 2011, CLCH appointed Liz Royle as Head of Safeguarding for Children and Adults in the organisation. Liz has joined the CLCH-Barnet Safeguarding Board.

**Work undertaken and achievements in 2011//2012**

- **Raising Awareness Event:** On April 6th 2011, CLCH-Barnet held a further Safeguarding Raising Awareness Day following on from the success of the event the year before. The event followed the same format as before with a three hour session in the morning, followed by a similar session in the afternoon. Annie Zlotnick, a free lance Facilitator and Linda Davies, the Safeguarding Lead Nurse at the Royal Free Hospital were the two speakers, each providing a different focus on identifying and responding to allegations of abuse in different settings. Over 70 staff from CLCH-Barnet attended the sessions, and the feedback from the evaluation forms was extremely positive.
- **Training in Mental Capacity Act:** CLCH has begun a programme of training in the Mental Capacity Act. A pilot training session took place on March 22nd, involving Liz Gale, the Mental Capacity Act Lead Practitioner for the London Borough of Kensington and Chelsea and Olly Bamford, a Community Matron from Inner London. It is planned to roll out a programme of training for all front line staff. This is particularly important as Community Staff are continually being faced with issues regarding patient concordance and need to assess whether the service user is able to make a decision regarding a refusal to accept treatment or follow the advice of a District Nurse.
- **CQC Compliance Inspections:** In the course of the past six months, the wards at Finchley Memorial Hospital and at Edgware Community Hospital, and the two Walk-In Centres have had unannounced inspections from the CQC. The Inspector focused on 5 Outcomes, including Outcome 7, (service users should be protected from abuse and staff should respect their human rights). In the course of the inspections of the wards and the Walk-In Centres, the Inspector found all the services were compliant.
- **Pressure Ulcers;** CLCH -Barnet has continued to attach a very high priority to the rapid identification and treatment of pressure ulcers. A target was set for the reduction of grade 3 and 4 pressure ulcers acquired in the Community setting of 50% as part of a CQUIN agreed with Commissioners. The Tissue Viability Nurse has worked closely with District Nursing Teams and with Nursing Staff on the wards to ensure they have the necessary knowledge and skills to provide effective treatment to patients with pressure ulcers. Over the past 6 months a CLCH Pressure Ulcer Working Group has been putting more formal systems in place for nursing services in the community and bedded areas across the organisation. This includes a monthly reporting system in compliance with NICE guidance, formal CLCH care plans for the management of pressure ulcers, specific training designed to meet the needs of clinicians, identified targeted TV support for teams that demonstrate a higher number grade3/4 pressure

ulcers, tissue viability link nurses across the CLCH localities, pressure care information leaflets for all patients seen by community nursing

- A robust system of reporting and monitoring of pressure ulcer grading and incidence has been implemented to continually monitor the efficacy of treatment. Community staff are very conscious of the safeguarding element of high grade pressure ulcers and actively assess for safeguarding during each assessment and care planning
- Training in Adult Safeguarding is mandatory for all CLCH staff and a one hour training session is held each month for new and existing staff who has not previously attended a training session. Discussions are in progress to coordinate the mandatory safeguarding training with the training dept in the headquarters of CLCH in Victoria

**Work planned for 2012/2013**
In the next year, the Barnet part of CLCH will focus on a number of key objectives:

1. Continue the roll-out of Mental Capacity Training for all font line staff, including District Nurses, staff working in the Walk-In Centres, and staff working on the wards and in Out-Patient settings.

2. Organize a programme of training in domestic violence for front line staff, particularly those working in Walk-in-Centres and District Nursing. We have liaised with the Local Authority and with their assistance have identified a suitable trainer.

3. In conjunction with colleagues in CLCH IN the inner London boroughs, and with other NHS organizations, work to ensure that the Datix incident recording system is able to record whether any reported incident should also be raised as a safeguarding alert. This will be an important step in helping to raise the number of safeguarding alerts and will enable us to identify those areas in the different services in Barnet where there has been an under-reporting of safeguarding alerts.

4. Ensure that all our front line staff, including District Nurses and staff working on the wards, have the necessary knowledge and skills for the identification and appropriate treatment of pressure ulcers. CLCH in Barnet has agreed on a further CQUIN for 2012-2013 with Commissioners from NCL in connection with the identification and treatment of grade 3 and grade 4 pressure ulcers, so this work will have a continued very high priority.

5. Arrange for an audit to be carried out in respect of Dignity in Care on the wards in the new Finchley Memorial Hospital and in Edgware Community Hospital in the course of 2012-2013 with the results of the audit being reported to CLCH's Executive Board and to the Barnet Multi-Agency Safeguarding Board.

**Ann Mount**
**Assistant Director of Operations**

**Andrew Wilkes**
**Divisional Manager, Urgent Care**

## Organisation: Barnet Safeguarding Children Board

### Work Undertaken and Achievements 2011-12

The Barnet Safeguarding Children Board ( BSCB) has its statutory basis in The Children Act 2004 which requires Local Authorities to establish Local Safeguarding Children Boards (LSCB) for their area.

The LSCB is the key statutory mechanism for agreeing how organisations will co-operate to safeguard and promote the welfare of children and for ensuring that partners are working together effectively. The importance of links with adult safeguarding is identified in the national guidance Working Together to Safeguard and Promote the welfare of Children (2010). Many children may live in families together with a vulnerable adult and close working links on the ground are essential to promote a holistic family approach. There are also cross cutting themes in relation to safeguarding vulnerable groups and working across services to ensure an integrated approach.

The following examples demonstrate particular areas of activity that have been undertaken in collaboration with SAB

- BSCB continues to be represented at SAB and the Safeguarding Adults Manager attends the BSCB to promote links at a strategic level. The Independent Chairs of respective Boards also meet on a regular basis to ensure collaborative approaches are maintained

- Safeguarding month in Nov 2011 provided an opportunity for further collaboration in relation to awareness raising events across the council and partner agencies. A diverse range of activities included a fire safety presentation from colleagues in the Fire Service which highlighted their valuable contribution to safeguarding children and vulnerable adults. Safeguarding Express training sessions were also delivered as well as events to raise awareness of domestic violence and procedures to protect victims.

- Further sessions in safeguarding adults and children were delivered to Elected Members as part of their development programme. Training was also provided to managers and board members of Barnet Homes and the safeguarding updates for GP's included procedures for adult as well as children's safeguarding.

- Faith and Cultural work undertaken as part of a London Safeguarding Children Board Project was extended in Barnet to include input from colleagues working with vulnerable adults who participated in the focus groups and on line questionnaire. This provided a wealth of information regarding the views of both communities and practitioners regarding safeguarding and perceptions of barriers in reporting concerns or accessing advice and support. Pan London Guidance has recently been developed as part of the project and will be a focus of activity during the forthcoming year

- A cross cutting 'cross generational' sub group has engaged in work to map areas of transition between adults and children's services. Information Sharing Guidance was

recirculated and a protocol to guide operational work between the Barnet Enfield and Haringey Mental Health Trust and 3 Children's Services was formally launched in September 2011.

- Barnet Safeguarding Children Board has piloted a SCIE case review in relation to a young child whose mother was murdered by her partner. A Domestic Violence Homicide Review also ran in parallel. Joint learning events are planned to disseminate learning from these reviews which have identified similar themes across both adults and children's partnerships.

**Work Planned for 2012-13**

- The Munro review into child protection will drive work to strengthen the accountability and quality assurance function of the BSCB which will include oversight of the effectiveness of the Troubled Families initiative which provides a co-ordinated service to families experiencing multiple problems.

- The existing Cross Generational Group will be refreshed with new Chair arrangements and revised Terms of Reference. Priorities identified include transition arrangements and continuing support for young adults who are identified as vulnerable but who may be below the threshold for services.

- BSCB will also support initiatives to establish improved information sharing at the front door via a Multi Agency Safeguarding Hub in order to better safeguard both children and adults.

**Helen Elliott**
**BSCB Development Manager**

## Organisation: NHS NCL Barnet

**Internal arrangements for governance regarding safeguarding adults at risk**

- NHS NCL Barnet reduced it's workforce by 50% in 2010/11 in line with national guidance. The five PCTs of North Central London (NCL) now work under a single management structure with responsibilities divided between the central NCL team and the borough teams.
- This process has led to a complete change in lead adult safeguarding managers at a borough level.
- The NHS NCL Director of Nursing and Quality provides strategic oversight and direction for adult safeguarding in NCL. At a borough level Borough Directors are responsible for adult safeguarding and discharge this responsibility through the Associate Director of Joint Commissioning and the Joint Commissioner for Older Adults and PSI.
- The Professional Executive Committee (PEC) is the responsible committee for adult safeguarding. A lead GP has been identified.

**Work undertaken and achievements in 2011/2012**

- NHS NCL Barnet participated in a Domestic Homicide Review in 2011/12. This identified some uncertainty in relation to data sharing between the NHS and investigation Panel. This uncertainty was resolved following legal advice.
- Adult safeguarding training to GPs continues to be delivered in tandem with children's safeguarding training. Training is delivered on a borough wide basis and within individual practices where they choose to join with other local practices for training. In 2011/12 training was delivered to 234 people within GP practices.
- NHS NCL holds regular quality meetings with local acute Trusts as part of the contract monitoring process. Safeguarding is included on the agenda of these meetings on a rolling basis. In addition the NCL Quality Team provides regular (6 monthly) reports to the NCL Joint Boards.
- A risk assessment of adult safeguarding in NHS NCL Barnet has recently been carried out by the Joint Commissioner for Older Adults and PSI and will be reviewed by the PEC in April 2012.
- Deprivation of Liberty requests have increased significantly in 2011/12. In part this is a result of the Winterbourne expose. Acute trusts were written to at the beginning of the year to remind them of their contractual responsibilities in relation to DOL.

**Work Planned for 2012/2013**

- NHS NCL Barnet will cease to exist as an entity in April 2013 when Clinical Commissioning Groups (CCG) will assume many of the responsibilities of PCTs. This will include safeguarding. Preparation of the CCG for this responsibility is a key priority for 2012/13.
- A CCG lead will be identified to support handover from the PEC during 2012/13. The CCG will also set up shadow quality and safeguarding meeting/committee structures during 2012/13 to ensure handover is seamless in April 2013.
- Training for GPs will continue. The risk assessment has identified a need to commit more resource to this process and this will be considered by the PEC in April 2012.

- The risk assessment has also identified a gap in capacity for assessment of significant events relating to pressure sores. This is currently being reviewed with our community nursing provider and again will be considered by the PEC in April.
- NHS NCL Barnet will seek to strengthen monitoring, review and reporting of adult safeguarding trends through 2012/13.
- Further work to raise awareness of DOL is required during 2012/13.
- The work plan for 2012/13 will be finalised following the PEC meeting in April.

**Ceri Jacob**
**Joint Associate Director of Joint Commissioning**

## Organisation: London Ambulance Service

### Introduction

The London Ambulance Service continues to strive to improve its safeguarding practice, which has resulted in a continual increase in referrals and requests for information and contributions to safeguarding investigations. The Trust's safeguarding structure is designed to support and embed best practice by collaborating with professional colleagues to ensure staff are familiar with national guidance. Further information about policy and processes can be found at www.londonambulance.nhs.uk.

### Incidents

| | Referrals made to social services | Feedback received from social services about referrals made | Requests for information | |
|---|---|---|---|---|
| **2011/12** | 368 | 4 | 3 | requests to review information |
| | | | 7 | general enquiries |
| **TOTAL** | **368** | **4** | **10** | |

During 2011/12 the Trust made 9,963 referrals pan London; local authorities fed back on 111 referrals and the Trust received 302 approaches to assist with multi-agency work to safeguard adults.

### Internal arrangements

- The Director of Health Promotion and Quality has responsibility for Safeguarding.
- The Trust continues to operate a safeguarding committee that reports into the Clinical Quality and Safety Executive Committee and is supported by separate Mental Health and Learning Disability committees.
- The Trust continues to cooperate and work with partners to improve practice and share learning as members of the London Safeguarding Adults Network, the Metropolitan Police Service Safeguarding Adults Group and hosting the National Ambulance Safeguarding Group.

### Achievements in 2011/12

- Appointment of a lead mental health practitioner.
- Completion of the Safeguarding Adults Audit Framework which led to the development and ongoing monitoring of the Trusts safeguarding adults action plan.
- Clinical staff participated in an annual core skills refresher course; this covers several safeguarding elements including sexual abuse perpetrated against adults with a learning disability; domestic violence and homeless people.

### Priorities for 2012/13

- Appointment of a Named Professional for Safeguarding Adults.
- Adoption and cascade of the pan London safeguarding adults at risk policy and guidance into the Trust's Safeguarding Adults Policy.
- Implementation of a telephone based referral system.
- Establishing a pilot to provide consistent, timely responses to support high risk victims of domestic violence via the Multi Agency Risk Assessment Conference.

- Review and update the safeguarding information on the website to enable the public to recognise and report abuse, and enable professionals to understand the Trusts processes.
- Introduction of the Operational Workplace Review to include observation of crew's ability to put safeguarding training into practice in a clinical setting.

**Ruth Williams**
**Community Involvement Officer**

## Appendix 2: National and Regional Developments

The following national and regional developments in both policy and research that will affect the safeguarding agenda are;-

1. **Domestic Homicide Reviews**
   Statutory guidance was issued by the Home Office under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004) to support Domestic homicide reviews. It introduced a duty upon local partners such as the police, local authority, probation service, health service and voluntary sector to establish a review in the event of a domestic homicide. These should be conducted to ensure lessons are learned when person has been killed as a result of domestic violence.

2. **ADSS Safeguarding Adults: Advice Note**
   In April 2011 the Association of Directors of Adults Social Services (ADASS) published a new advice note to support Directors of Adult Social Services in their leadership role regarding adult safeguarding. The framework has been developed by ADASS National Safeguarding Adults Policy Network. It makes the following recommendations for consideration by Directors of Adult Social Care Services:

   1. Develop or review the safeguarding strategy of the Board, embedding an outcomes focus throughout, and ensuring that procedures are sufficiently sensitive to respond to people's choices.
   2. Provide Annual report of the effectiveness of the Safeguarding Adult Board to all partner organisations and the public to assess the delivery of outcomes.
   3. Review risk enabling and risk management policies and practice to ensure that safeguarding and personalisation are addressed and people can weigh up the risks and benefits of their options.
   4. Develop a portfolio of responses to safeguarding situations that support positive outcomes.
   5. Review the Workforce Strategy to ensure it supports the workforce to be competent in safeguarding adults
   6. Share with partners locally and regionally, to support partner organisations and agencies to ensure that their own leadership of the safeguarding agenda is effective.
   7. Share with partner bodies at a national level, e.g. NHS Confederation and ACPO, to develop a partnership approach to safeguarding adults (ADASS to lead)

3. **ADASS Carers and Safeguarding Adults – Working Together to Improve Outcomes**.
   Following the new principles set out within the vision for Adult Social Care, and the refreshed national strategy for carers 'Recognised Valued and Supported' ADASS published a report setting out seven key messages in relation to carers abusing those in their care and carers being abused by those that they care for. The key messages include: Leadership; Partnership; Empowerment; Prevention; Recognition & Reporting; Protection &Proportionality; Learning & Accountability.

4. **Law Commission publishes Adult Social Care in May 2011** which reviews adult social care law in England and Wales and contains recommendations for reform. The Government committed to consider the conclusions of the report, with a view to introducing legislation in the second session of this Parliament. The report recommends a three level structure containing new statute, regulations and a code of practice. In relation to safeguarding adults it recommends to "safeguard adults wherever practicable from

abuse and neglect; and to “use the least restrictive solution where it is necessary to interfere with the individual’s rights and freedom of action wherever that is practicable”.

5. **Statement of Government Policy on Adult Safeguarding** issued in May 2011
   This includes a statement of principles for use by Local Authority Social Services and housing, health, the Police and other agencies for both developing and assessing the effectiveness of their local safeguarding arrangements. It also introduces specific safeguarding outcome principles, which we are encouraged to use to develop our strategic action plan. They are :-

   Empowerment - Presumption of person led decisions and informed consent.

   Protection - Support and representation for those in greatest need.

   Prevention - It is better to take action before harm occurs.

   Proportionality – Proportionate and least intrusive response appropriate to the risk presented.

   Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

   Accountability - Accountability and transparency in delivering safeguarding

6. **SCIE Report 41: Prevention in Adult Safeguarding May 2011**
   This report shares findings from research, policy and practice on prevention in adult safeguarding and presents a wide range of approaches that can help prevent abuse. Its key message is that effective prevention in safeguarding needs to be broadly defined and should include all social care user groups and service configurations. It does not mean being over-protective or risk-averse.

7. **London Fire Brigade, Policy Number 736 Safeguarding Adults at Risk Policy**
   This new policy Safeguarding Adults at Risk was developed to set out the internal procedures to follow when receiving referrals from staff. It provides advice to all staff on how to report a safeguarding concern involving an adult at risk. The policy aligns with the London multi-agency policy and procedures to safeguard adults from abuse and also describes the role of the Borough Commanders in the Safeguarding Adults Partnership Board within the London boroughs. Borough Commanders, as members of safeguarding adult’s boards, are instructed, as ideally placed, to develop links with agencies responsible for safeguarding adults at risk.

8. **The Equality and Human Rights Commission: Hidden in Plain Sight: Inquiry into disability-related harassment**
   Report into disability harassment and its impact. Those serious cases which come to court and receive media attention are just tip of the iceberg. Disabled people often do not report harassment for a number of reasons. There is a systemic failure by public authorities to recognise the extent and impact and abuse of disabled people, take action to prevent it happening in the first place and intervene effectively when it does. There are key safeguarding sections in the report.

9. **The Care Quality Commission: The State of Health Care & Adult Social Care in England**
   An overview of key themes in care in 2010/11 This includes the early findings alongside national statistics and NHS patient surveys provide a picture of quality and safety, and findings from CQC reviews of compliance with outcome 7 on safeguarding.

10. **The Governance of adult safeguarding: findings from research into Safeguarding Adult Boards SCIE**
    This report was commissioned by the Department of Health. The report looks at how the boards have been structured, their membership and their strategic goals, vision and purpose.

11. **Self-Neglect and adult Safeguarding: Findings from Research SCIE**
    This report comprised of a scoping study on the concept of self-neglect as defined in the literature and interpreted in adult safeguarding practice. The report draws on a systematic review of the literature, workshops with senior managers and practitioners in specialist safeguarding roles, a focus group with adult social care practitioners and interviews with key informants.

12. **SCIE: The governance of adult safeguarding: findings from research into Safeguarding Adults Boards**
    The Department of Health (DH) commissioned this research which took place between December 2009 and May 2010. It draws on evidence from literature and from the practice of Safeguarding Adults Boards, and explores the governance arrangements for safeguarding adults in England.

13. **SCIE: Safeguarding adults at risk of harm: A legal guide for practitioners by Michael Mandelstam**
    This guide outlines the legal basis for the safeguarding of vulnerable adults at risk of harm in England. It is intended to give practitioners useful legal pointers but every case is different and should be taken on its own merits.

14. **The NHS Information Centre: Abuse of Vulnerable Adults in England 2010-11 Experimental Statistics Provisional Report**
    This report contains provisional information on alerts and referrals to adult social care safeguarding teams derived from the Abuse of Vulnerable Adults (AVA) data collection for the period 2010-11. It presents a variety of information on aspects of the safeguarding process, including type of alleged abuse, source of referral, location of alleged abuse, relationship between alleged victim and perpetrator and outcomes. Final data for 2010-11 is expected to be published in early March 2012.

15. **The Equality and Human Rights Commission: Close to Home: An Enquiry into Older People and Human Rights in Home Care**
    The Commission's inquiry into the home care system in England reveals disturbing evidence that the poor treatment of many older people is breaching their human rights and too many are struggling to voice their concerns about their care or be listened to about what kind of support they want.

16. **SCIE: Assessment Financial Crimes Against Vulnerable Adults**
    This assessment, commissioned by the Association of Chief Police Officers (ACPO) Economic Crime Portfolio, has been produced to highlight the current and potential future threats to vulnerable adults in relation to economic crime. It covers the wide spectrum of financial abuse and exploitation against vulnerable people by family members, care workers and unscrupulous individuals within our society

17. **Alzheimer's Society: Short Changed: Protecting People from Dementia from Financial Abuse**
    This report gathers new evidence about the issues that people with dementia and carers

face when managing their money. It also explores what they consider to be financial abuse. The report makes recommendations for helping people with dementia and carers to manage their money as well as possible, for as long as possible, while minimising the risks of financial abuse.

18. **Home Office: Missing Children and Adults A Cross Government Strategy** This strategy, which focuses primarily on vulnerable people who go missing within England and Wales, provides a framework for local areas to put in place their own arrangements. It seeks to ensure we do all we can to prevent people going missing in the first place, that we also reduce the harm to vulnerable children and adults when they do go missing, that we focus on those most at risk, and ensure that families are supported.

## Appendix 3: Safeguarding Monitoring Report

London Borough of Barnet Adult Social Care and Health

# Safeguarding Adult Referrals Monitoring Report

Annual Report
1st April 2011 – 31st March 2012

Sue Smith, Safeguarding Adults Manager
Tel: 020 8359 6105

E-mail: sue.smith@barnet.gov.uk

- Information in this report was supplied by Social Work Teams and CMHT in Barnet

- The data is drawn from the Safeguarding Adult Monitoring Forms, completed after receiving an alert of abuse.

- The data relates to incidents with a 'date of alert' received between **1st April 2011 – 31st March 2012**

- Adults at risk can have a 'learning disability', 'physical disability', 'sensory impairment', 'mentally ill', an 'older person', or any combination of these.

- Between **1st April 2011 – 31st March 2012** there were a total of **540** alerts received.

# Analysis of Safeguarding Adults Referrals to Barnet Social Work Teams during the period from 1st April 11 ~ 31st March 12.

*Total number of alerts during the period was:* **540**

## *Total alerts by quarter*

| | | |
|---|---|---|
| **I** | 01 April 2011 - 31 June 2011 | **130** |
| **II** | 01 July 2011 - 31 Sep 2011 | **142** |
| **III** | 01 Oct 2011 - 31 Dec 2011 | **138** |
| **IV** | 01 Jan 2012 - 31 March 2012 | **130** |
| **Total in 2011-12** | | **540** |
| Total in 2010-11 | | 495 |
| Total in 2009-10 | | 420 |

## *1) Referrer's relationship to the adult at risk*

The table below indicates the source of the alerts and their relationship to the adult at risk

| | **Total Alerts** | Total alerts in 2010-11 | Total alerts in 2009-10 |
|---|---|---|---|
| Self Referral | **19** | 23 | 20 |
| Anonymous | **7** | 1 | 1 |
| Other service user | **2** | 0 | 0 |
| Family / Friends | **55** | 53 | 58 |
| Paid Carer | **189** | 164 | 127 |
| Agency | **268** | 254 | 214 |
| Total Alerts | **540** | 495 | 420 |

## *Referrers relationship to the adult at risk by quarter*

| **Quarter** | Self Referral | Anonymous | Other service user | Family / Friends | Paid Carer | Agency | Total Alerts |
|---|---|---|---|---|---|---|---|
| **I** | **0** | **0** | **1** | **10** | **59** | **60** | **130** |
| **II** | **4** | **5** | **1** | **8** | **48** | **76** | **142** |
| **III** | **4** | **2** | **0** | **19** | **52** | **61** | **138** |
| **IV** | **11** | **0** | **0** | **18** | **30** | **71** | **130** |
| **Total** | **19** | **7** | **2** | **55** | **189** | **268** | **540** |

## *1a) Alerts from 'Agency'*

Those alerts from 'other agencies' are further broken down to indicate which agency they came from:

| | **Total Alerts** | Total alerts in 2010-11 | Total alerts in 2009-10 |
|---|---|---|---|
| Social Worker | **25** | 34 | 42 |
| Other Local Authority (OLA) | **22** | 16 | 7 |
| Central London Community Healthcare (CLCH) | **31** | 20 | 22 |
| Education / Workplace | **1** | 0 | 0 |
| CQC | **5** | 4 | 2 |
| Police | **13** | 13 | 9 |
| London Ambulance Service (LAS) | **8** | 8 | 7 |
| Advocacy Service | **2** | 2 | 2 |
| Mental Health Staff | **65** | 69 | 46 |
| Housing | **7** | 10 | 15 |
| NHS staff | **75** | 50 | 42 |
| Other agency | **14** | 28 | 20 |
| Total | **268** | 254 | 214 |

## *Alerts from 'Agency' by quarter*

| Quarter | Social Worker | OLA | CLCH | Education / Workplace | CQC | Police | LAS | Advocacy Service | MHT | Housing | NHS staff | Other agency | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| I | 6 | 7 | 5 | 0 | 0 | 2 | 2 | 0 | 17 | 1 | 19 | 1 | 60 |
| II | 8 | 4 | 10 | 0 | 2 | 5 | 2 | 0 | 19 | 2 | 17 | 7 | 76 |
| III | 4 | 6 | 6 | 0 | 2 | 0 | 2 | 1 | 17 | 1 | 21 | 1 | 61 |
| IV | 7 | 5 | 10 | 1 | 1 | 6 | 2 | 1 | 12 | 3 | 18 | 5 | 71 |
| Total | 25 | 22 | 31 | 1 | 5 | 13 | 8 | 2 | 65 | 7 | 75 | 14 | 268 |

***NHS staff refers to: 35** x RFH, **27** x BGH, **3** x NPH, **2** x Continuing Care Team, **2** x Harperbury Hospital, **2** x Whittington Hospital, **1** x UCLH, **1** x North West Hospital, **1** x Chase Farm Hospital, **1** x Guy's and St. Thomas's Hospital,*

## *1b) Alerts from 'Paid Carer'*

This table indicates in more detail those cases referred by paid carers.

| | Total | Total alerts in 2010-11 | Total alerts in 2009-10 |
|---|---|---|---|
| Care Home | 80 | 55 | 43 |
| Care home with Nursing | 25 | 25 | 17 |
| Domiciliary Care | 18 | 22 | 33 |
| Day Service | 16 | 22 | 0 |
| Selfdirected Care Staff | 0 | 0 | 13 |
| Other Paid Carer | 50 | 40 | 21 |
| Total | 189 | 164 | 127 |

## *Alerts from 'Paid Carer' by quarter*

| Quarter | Care Home | Care home with Nursing | Domiciliary Care | Day Service | Selfdirected care staff | Other paid carer | Total |
|---|---|---|---|---|---|---|---|
| I | 24 | 6 | 8 | 9 | 0 | 12 | 59 |
| II | 25 | 5 | 3 | 2 | 0 | 13 | 48 |
| III | 23 | 7 | 3 | 3 | 0 | 16 | 52 |
| IV | 8 | 7 | 4 | 2 | 0 | 9 | 30 |
| Total | 80 | 25 | 18 | 16 | 0 | 50 | 189 |

## *2) Breakdown of primary client group*

| | Total Alerts | Total alerts in 2010-11 | Total alerts in 2009-10 |
|---|---|---|---|
| Learning Disabilities** | 150 | 143 | 95 |
| Physical Disabilities | 34 | 23 | 40 |
| HIV | 1 | 1 | 0 |
| Older People* | 263 | 232 | 166 |
| Sensory Impairment | 2 | 3 | 1 |
| Mental Health*** | 82 | 91 | 83 |
| Substance Misuse | 0 | 2 | 0 |
| Combination | 8 | 0 | 35 |
| Total Alerts | 540 | 495 | 420 |

***24** older adults cases refer to individuals who have additional mental health needs

***1** older adult case was referred to PCMHT

***1** adult with physical disability was referred to PCMHT

****3** cases of adults with a learning disability were referred to BGH and **2** cases were referred to Right to Control social work team.

*** **1** mental health case was referred to CT North

**Of the 540 alerts received, 142 people have dementia**

### *3) Number of alerts to each team and categories of abuse referred*

| Team | Total | Physical | Neglect | Sexual | Financial | Psychological | Discriminatory | Institutional | Combinations | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Learning Disabilities | **141** | **57** | **37** | **5** | **11** | **3** | **1** | **3** | **24** | **141** |
| Transitions Team | **4** | **1** | **0** | **1** | **0** | **1** | **0** | **0** | **1** | **4** |
| ***Older Adults:*** | | | | | | | | | | |
| Social Care Direct | **35** | **12** | **7** | **0** | **11** | **3** | **0** | **0** | **2** | **35** |
| Short Term Enablement & Planning Team | **11** | **1** | **2** | **1** | **5** | **0** | **0** | **0** | **2** | **11** |
| Complex Planning & Ongoing Support North | **40** | **4** | **12** | **0** | **11** | **1** | **0** | **0** | **12** | **40** |
| Complex Planning & Ongoing Support West | **44** | **6** | **11** | **3** | **9** | **2** | **1** | **2** | **10** | **44** |
| Complex Planning & Ongoing Support South | **61** | **16** | **23** | **0** | **12** | **2** | **0** | **0** | **8** | **61** |
| Review and Reassessment Team | **4** | **0** | **2** | **0** | **0** | **0** | **0** | **0** | **2** | **4** |
| Right to Control | **3** | **2** | **0** | **0** | **1** | **0** | **0** | **0** | **0** | **3** |
| ***Hospitals:*** | | | | | | | | | | |
| Barnet | **36** | **4** | **13** | **1** | **1** | **3** | **0** | **0** | **14** | **36** |
| Edgware | **2** | **0** | **0** | **1** | **1** | **0** | **0** | **0** | **0** | **2** |
| Northwick Park | **1** | **0** | **1** | **0** | **0** | **0** | **0** | **0** | **0** | **1** |
| Finchley Memorial | **4** | **1** | **0** | **0** | **0** | **0** | **0** | **0** | **3** | **4** |
| ICS | **1** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **1** |
| Royal Free | **42** | **4** | **15** | **1** | **3** | **2** | **0** | **1** | **16** | **42** |
| ***Mental Health:*** | | | | | | | | | | |
| CSRT East | **4** | **0** | **0** | **0** | **1** | **1** | **0** | **0** | **2** | **4** |
| CSRT West | **22** | **5** | **1** | **1** | **5** | **2** | **0** | **0** | **8** | **22** |
| Community Rehabilitation Team | **16** | **2** | **2** | **0** | **6** | **2** | **0** | **0** | **4** | **16** |
| Primary Care Mental Health Team | **10** | **0** | **0** | **1** | **0** | **2** | **0** | **0** | **7** | **10** |
| Cognitive Impairment - East | **18** | **5** | **0** | **3** | **5** | **3** | **0** | **0** | **2** | **18** |
| Cognitive Impairment - West | **6** | **0** | **0** | **1** | **1** | **2** | **0** | **0** | **2** | **6** |
| Crisis and Emergency | **8** | **2** | **0** | **3** | **0** | **0** | **0** | **0** | **3** | **8** |
| Barnet Drug & Alcohol Service | **1** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **1** |
| Complex Care Team | **15** | **3** | **0** | **0** | **2** | **3** | **0** | **0** | **7** | **15** |
| Early Intervention Service | **6** | **1** | **0** | **1** | **1** | **0** | **1** | **0** | **2** | **6** |
| IAPT | **5** | **1** | **0** | **0** | **0** | **0** | **0** | **0** | **4** | **5** |
| Other | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **TOTAL** | **540** | **127** | **126** | **23** | **86** | **32** | **3** | **6** | **137** | **540** |

### *3a) Number of alerts to each team by quarter*

| Team | I | II | III | IV | Total |
|---|---|---|---|---|---|
| Learning Disabilities | 42 | 47 | 39 | 13 | **141** |
| Transitions Team | 0 | 1 | 1 | 2 | **4** |
| ***Older Adults:*** | | | | | |
| Social Care Direct | 4 | 4 | 9 | 18 | **35** |
| Short Term Enablement & Planning Team | 3 | 4 | 2 | 2 | **11** |
| Complex Planning & Ongoing Support North | 6 | 14 | 7 | 13 | **40** |
| Complex Planning & Ongoing Support West | 11 | 8 | 10 | 15 | **44** |
| Complex Planning & Ongoing Support South | 17 | 11 | 16 | 17 | **61** |
| Review and Reassessment Team | 1 | 3 | 0 | 0 | **4** |
| Right to Control | 0 | 1 | 1 | 1 | **3** |
| ***Hospitals:*** | | | | | |
| Barnet | 8 | 8 | 9 | 11 | **36** |
| Edgware | 0 | 1 | 0 | 1 | **2** |
| Northwick Park | 0 | 0 | 0 | 1 | **1** |
| Finchley Memorial | 0 | 2 | 1 | 1 | **4** |
| ICS | 0 | 1 | 0 | 0 | **1** |
| Royal Free | 16 | 9 | 12 | 5 | **42** |
| ***Mental Health:*** | | | | | |
| CSRT East | 0 | 2 | 2 | 0 | **4** |
| CSRT West | 5 | 4 | 6 | 7 | **22** |
| Community Rehabilitation Team | 3 | 5 | 4 | 4 | **16** |
| Primary Care Mental Health Team | 1 | 4 | 4 | 1 | **10** |
| Cognitive Impairment - East | 4 | 2 | 4 | 8 | **18** |
| Cognitive Impairment - West | 2 | 1 | 2 | 1 | **6** |
| Crisis and Emergency | 4 | 0 | 1 | 3 | **8** |
| Barnet Drug & Alcohol Service | 0 | 0 | 1 | 0 | **1** |
| Complex Care Team | 3 | 5 | 3 | 4 | **15** |
| Early Intervention Service | 0 | 5 | 1 | 0 | **6** |
| IAPT | 0 | 0 | 3 | 2 | **5** |
| Other | 0 | 0 | 0 | 0 | **0** |
| **TOTAL** | **130** | **142** | **138** | **130** | **540** |

## *4) Type of abuse*

| | Total | Total alerts in 2010-11 | Total alerts in 2009-10 |
|---|---|---|---|
| Physical | **127** | 138 | 92 |
| Neglect | **126** | 73 | 57 |
| Sexual | **23** | 29 | 42 |
| Financial | **86** | 109 | 79 |
| Psychological / Emotional | **32** | 34 | 36 |
| Discriminatory | **3** | 0 | 1 |
| Institutional | **6** | 4 | 5 |
| Combination* | **137** | 108 | 108 |
| **Total Alerts** | **540** | 495 | 420 |

**61** cases were reported, where **neglect, physical and institutional** type of abuse resulted into pressure sore development grade 3-4.

**Combination* (more then 1 type of abuse referred) refers to (see table below):**

| Physical | Neglect | Sexual | Financial | Psychological / Emotional | Discriminatory | Institutional | **Total** |
|---|---|---|---|---|---|---|---|
| x | x | | | | | | 20 |
| x | | x | | | | | 7 |
| x | | | x | | | | 4 |
| x | | | | x | | | 34 |
| x | | | | x | x | | 2 |
| x | | | | | | x | 3 |
| x | | | x | x | | | 2 |
| x | x | | | x | | | 4 |
| x | x | | | | | x | 1 |
| x | x | | | | x | | 1 |
| x | x | | x | | | | 1 |
| x | x | | x | | x | | 1 |
| x | | | | | x | | 2 |
| x | | x | x | x | | | 1 |
| | | | x | x | | | 12 |
| | x | | x | | | | 8 |
| | x | | x | x | | | 2 |
| | x | | | x | | | 3 |
| | x | | | x | x | | 1 |
| | x | | | x | | x | 2 |
| | x | | | | x | | 1 |
| | x | | | | | x | 12 |
| | | x | | x | | | 3 |
| | | x | x | | | | 3 |
| | | x | | | | x | 1 |
| | | | | x | | x | 1 |
| | | | | x | x | | 5 |
| | | | | | | | **137** |

## *4a) Type of abuse by primary client group*

| | LD | PD | HIV | Older People | SI | Mental Health | Subs. Misuse | Combination* | **Total** |
|---|---|---|---|---|---|---|---|---|---|
| Physical | **60** | **2** | **0** | **49** | **1** | **14** | **0** | **1** | **127** |
| Neglect | **37** | **10** | **1** | **74** | **0** | **3** | **0** | **1** | **126** |
| Sexual | **6** | **1** | **0** | **10** | **0** | **6** | **0** | **0** | **23** |
| Financial | **11** | **7** | **0** | **52** | **0** | **16** | **0** | **0** | **86** |
| Psychological / Emotional | **4** | **3** | **0** | **14** | **0** | **9** | **0** | **2** | **32** |
| Discriminatory | **1** | **1** | **0** | **0** | **0** | **1** | **0** | **0** | **3** |
| Institutional | **3** | **0** | **0** | **3** | **0** | **0** | **0** | **0** | **6** |
| Combination | **28** | **10** | **0** | **61** | **1** | **33** | **0** | **4** | **137** |
| **Total Alerts** | **150** | **34** | **1** | **263** | **2** | **82** | **0** | **8** | **540** |

*See 2) for explanation of combination of Client Group

## *4b) Type of abuse by person who caused the harm*

| | Friends/ Family | Stranger | Professional | Paid Carer | Other adult at risk | Not known | Other | **Total** |
|---|---|---|---|---|---|---|---|---|
| Physical | **38** | **4** | **1** | **36** | **33** | **14** | **1** | **127** |
| Neglect | **14** | **1** | **6** | **97** | **0** | **7** | **1** | **126** |
| Sexual | **3** | **3** | **1** | **1** | **13** | **1** | **1** | **23** |
| Financial | **34** | **10** | **2** | **15** | **3** | **14** | **8** | **86** |
| Psychological / Emotional | **20** | **1** | **1** | **6** | **1** | **1** | **2** | **32** |
| Discriminatory | **1** | **1** | **0** | **0** | **0** | **1** | **0** | **3** |
| Institutional | **0** | **0** | **0** | **6** | **0** | **0** | **0** | **6** |
| Combination | **63** | **13** | **7** | **40** | **3** | **8** | **3** | **137** |
| **Total Alerts** | **173** | **33** | **18** | **201** | **53** | **46** | **16** | **540** |

## *4c) Gender of the adults at risk referred and the type of abuse*

| | Male | Female | Not known | Missing Data | **Total** |
|---|---|---|---|---|---|
| Physical | **58** | **69** | **0** | **0** | **127** |
| Neglect | **56** | **70** | **0** | **0** | **126** |
| Sexual | **5** | **18** | **0** | **0** | **23** |
| Financial | **39** | **47** | **0** | **0** | **86** |
| Psychological / Emotional | **10** | **21** | **1** | **0** | **32** |
| Discriminatory | **2** | **1** | **0** | **0** | **3** |
| Institutional | **3** | **2** | **1** | **0** | **6** |
| Combination* | **49** | **84** | **4** | **0** | **137** |
| **Total Alerts** | **222** | **312** | **6** | **0** | **540** |

**See 4) for explanation of combination of abuse*

## *5) Locations where alleged abuse took place*

| | **Total** | Total alerts in 2010-11 | Total alerts in 2009-10 |
|---|---|---|---|
| Own home | **200** | 182 | 194 |
| Home of the person who caused the alleged harm | **10** | 20 | 3 |
| Care Home - permanent | **95** | 85 | 57 |
| Care Home - temporary | **15** | 11 | 20 |
| Care Home with Nursing - permanent | **67** | 46 | 43 |
| Care Home with Nursing - temporary | **2** | 1 | 0 |
| Day Centre / Service | **13** | 7 | 8 |
| Community Hospital | **1** | 3 | 1 |
| Acute Hospital | **11** | 6 | 11 |
| Mental Health Inpatient Setting | **8** | 4 | 3 |
| Supported accommodation | **38** | 33 | 23 |
| Other Health Setting | **0** | 0 | 1 |
| Public Place | **26** | 20 | 30 |
| Education / Workplace | **1** | 0 | 0 |
| Other | **10** | 16 | 23 |
| N/K | **26** | 37 | 3 |
| Combination | **17** | 24 | 0 |
| **Total Alerts** | **540** | 495 | 420 |

## *6) How did the alleged abuse come to light?*

The table below indicates how the abuse had come to the attention of the referrer

| | **Total** | Total alerts in 2010-11 | Total alerts in 2009-10 |
|---|---|---|---|
| Disclosure | **240** | 238 | 205 |
| Witnessed | **75** | 65 | 57 |
| Physical signs | **92** | 70 | 38 |
| Suspicion | **12** | 40 | 43 |
| Combination of above | **69** | 48 | 55 |
| Other | **52** | 34 | 22 |
| **Total Alerts** | **540** | 495 | 420 |

## *7) Information about the person who caused the harm*

The table below indicates the relationship of the alleged person who caused the harm to the adult at risk

| | **Total** | Total alerts in 2010-11 | Total alerts in 2009-10 |
|---|---|---|---|
| Family / Friends | **173** | 182 | 173 |
| Stranger | **33** | 16 | 24 |
| Professional | **18** | 14 | 9 |
| Paid Carer | **201** | 147 | 133 |
| Other Service User | **53** | 42 | 28 |
| N/K | **46** | 82 | 43 |
| Other | **16** | 12 | 10 |
| **Total Alerts** | **540** | 495 | 420 |

### *8) Ethnic origin of the adult at risk**

| | **Total** | Total alerts in 2010-11 | Total alerts in 2009-10 |
|---|---|---|---|
| Asian/Asian British Bangladeshi | **5** | 1 | 1 |
| Asian/Asian British Indian | **32** | 33 | 27 |
| Asian/Asian British Other | **7** | 8 | 6 |
| Asian/Asian British Pakistani | **2** | 3 | 0 |
| Black/Black British African | **22** | 16 | 14 |
| Black/Black British Caribbean | **15** | 12 | 8 |
| Black/Black British Other | **6** | 3 | 7 |
| Chinese | **7** | 0 | 0 |
| White British | **308** | 300 | 245 |
| White Irish | **16** | 14 | 17 |
| White Other | **61** | 64 | 51 |
| N/A | **6** | 1 | 2 |
| Not stated | **11** | 19 | 18 |
| Mixed Other | **0** | 5 | 0 |
| Mixed White / Asian | **3** | 1 | 0 |
| Mixed White / Black | **6** | 1 | 0 |
| Any Other Ethnic Group | **33** | 14 | 24 |
| Total | **540** | 495 | 420 |

**Ethnic Origin was defined via swift code*

### *8a) Faith of the adult at risk**

| | **Total** | Total alerts in 2010-11 | Total alerts in 2009-10 |
|---|---|---|---|
| Buddhist | **4** | 4 | 1 |
| Christian | **233** | 216 | 184 |
| Hindu | **20** | 22 | 18 |
| Jewish | **96** | 93 | 60 |
| Muslim | **33** | 17 | 17 |
| Sikh | **2** | 2 | 1 |
| No religion | **44** | 28 | 56 |
| Not stated | **98** | 111 | 77 |
| Other | **10** | 2 | 6 |
| Total | **540** | 495 | 420 |

**Religion was defined via swift code*

### *9) Information about the funding authority*

| | **Total Alerts** |
|---|---|
| Funded by LBB | 313 |
| Funded by Health | 43 |
| Self funded | 55 |
| Another Council** | 46 |
| No service | 77 |
| Combination* | 5 |
| Missing information | 1 |
| Total Alerts | **540** |

* ***Combinations referrs to:*** ***3*** *x join funding of LBB and Health,* ***1*** *x join funding of LBB and self-funding,* ***1*** *x join funding of LBB, self-funding and Health*

** ***Other council refers to:*** ***16*** *x Camden,* ***1*** *x Waltham Forest,* ***1*** *x Hounslow,* ***8*** *x Brent,* ***1*** *x Ealing,* ***1*** *x Gateshed,* ***1*** *x Harrow,* ***4*** *x Haringey,* ***3*** *x Westminster,* ***1*** *x Enfield,* ***2*** *x Essex,* ***1*** *x Hackney,* ***2*** *x Scottish Social Services,* ***2*** *x Kensington & Chelsea,* ***2*** *x Bedfordshire,*

### *10) Comparison between gender of adults at risk and gender of alleged person who caused the harm*

| | **Total** | | Total alerts in 2010-11 | | Total alerts in 2009-10 | |
|---|---|---|---|---|---|---|
| | Adult at risk | Person who caused the harm | Adult at risk | Person who caused the harm | Adult at risk | Person who caused the harm |
| Male | **222** | **215** | 163 | 178 | 162 | 160 |
| Female | **312** | **114** | 331 | 118 | 255 | 112 |
| Not known | **N/A** | **191** | N/A | 174 | N/A | 54 |
| More than 1 person* | **6** | **20** | 1 | 25 | 3 | 94 |
| Total Alerts | **540** | **540** | 495 | 495 | 420 | 420 |

***** *In 6 cases the alert relates to more than one adult at risk*

## *11) Alleged person who caused the harm by primary client group*

| | Friends& Family | Stranger | Professionals | Paid Carer | Other service user | Not known | Other | Total |
|---|---|---|---|---|---|---|---|---|
| Learning Disabilities | **23** | **13** | **5** | **59** | **30** | **18** | **2** | **150** |
| Physical Disabilities | **11** | **2** | **2** | **13** | **2** | **4** | **0** | **34** |
| HIV | **0** | **0** | **0** | **1** | **0** | **0** | **0** | **1** |
| Older People | **85** | **7** | **9** | **119** | **12** | **21** | **10** | **263** |
| Sensory Impairment | **1** | **0** | **0** | **1** | **0** | **0** | **0** | **2** |
| Mental Health | **49** | **10** | **2** | **7** | **8** | **3** | **3** | **82** |
| Drug & Alcohol Misuse | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| Combination | **4** | **1** | **0** | **1** | **1** | **0** | **1** | **8** |
| Total Alerts | **173** | **33** | **18** | **201** | **53** | **46** | **16** | **540** |

## *12) Summary of action agreed*

*Of the **540** cases referred for this year:*

*Of the **448** cases that proceeded to strategy meeting:*

***448** proceeded to strategy meeting*
***92** cases had an alternative outcome.*

***382** forms were completed*
***66** were still ongoing.*

| | **Total** |
|---|---|
| Arrange Strategy meeting | **448** |
| Alternative Outcome | **92** |
| Total Alerts | **540** |

| | |
|---|---|
| Allocate Case & Community Care Assessment & I.P.P.* & Other action | **1** |
| Allocate Case & Community Care Assessment & Other action & N.F.A.** | **1** |
| Allocate case & Other action | **6** |
| Care Plan Approach & Other action | **1** |
| Disciplinary action & Other action | **2** |
| Interim protection plan & Other action | **1** |
| Other action & N.F.A. | **25** |
| Refer to other agency & Other action & N.F.A. | **7** |
| N.F.A. | **48** |
| **Total Alerts - Alternative Outcome** | **92** |

*I.P.P. - Interim Protection Plan
**N.F.A. - No Further Action

**The speed of response:**

~ The average number of days between receiving the alert to the day of the strategy meeting is **4.**
~ In **270** cases a strategy meeting was held within four days.
~ In **84** cases a strategy meeting was held between 4 and 10 days
~ In **27** cases a strategy meeting was held 10 days after receiving the alert or longer.
~ In **1** case - date of strategy meeting is unknown

## 13) Attendance of other agencies at strategy meetings and case conferences

| | Strategy Meeting | Case Conference |
|---|---|---|
| Police | **64** | **20** |
| Adult Social Services | **306** | **152** |
| Other Local authorities | **70** | **25** |
| CQC | **77** | **38** |
| Barnet Community Service | **35** | **20** |
| MHT | **89** | **40** |
| GP | **12** | **2** |
| RFH | **25** | **15** |
| BGH | **18** | **7** |
| ECH | **4** | **0** |
| FMH | **2** | **0** |
| Other NHS | **19** | **3** |
| Domiciliary Care | **44** | **26** |
| Care Home | **125** | **77** |
| Other provider | **46** | **20** |
| Adult at risk | **N/A** | **40** |
| Family | **N/A** | **48** |
| IMCA | **N/A** | **2** |
| Advocate | **N/A** | **8** |
| Other agency | **66** | **29** |

## 14) Case Conclusion: On the balance of probabilities

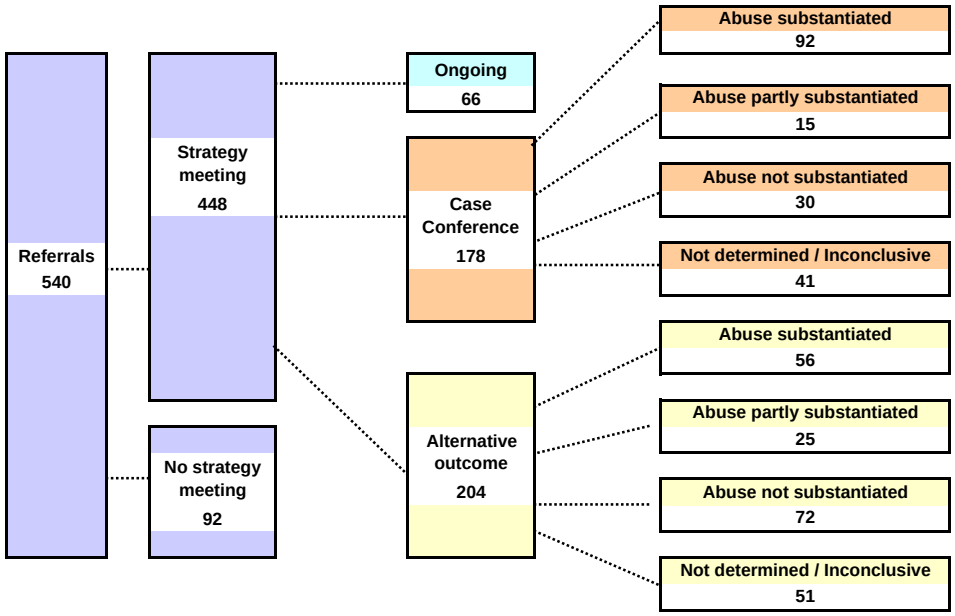
| | Total | Total in 2010-11 | Total in 2009-10 |
|---|---|---|---|
| Abuse Substantiated | **148** | 150 | 93 |
| Abuse Not Substantiated | **102** | 113 | 134 |
| Abuse Partly Substantiated | **40** | 59 | 57 |
| Not Determined / Inconclusive | **92** | 104 | 101 |
| Still Ongoing | **66** | 3 | 0 |
| Alternative Outcome* | **92** | 66 | 35 |
| Total Alerts | **540** | 495 | 420 |

**Alternative outcome: see 13) for those that did not proceed to the strategy meeting.*

## 15) Quarterly Comparison of Case Conclusion

| Quarter | Substantiated | Not substantiated | Partly substantiated | Not determined / Inconclusive | Still ongoing | Alternative outcomes | Total completed |
|---|---|---|---|---|---|---|---|
| **I** | 39 | 26 | 16 | 25 | 1 | 23 | **106** |
| **II** | 52 | 28 | 10 | 25 | 6 | 21 | **115** |
| **III** | 37 | 28 | 5 | 24 | 17 | 27 | **94** |
| **IV** | 20 | 20 | 9 | 18 | 42 | 21 | **67** |
| **Total** | **148** | **102** | **40** | **92** | **66** | **92** | **382** |

## 16) Outcome flowchart



## *17) Summary of action taken for the adult at risk who were referred*

**Number of cases where action was taken/service offered for the adult at risk**

| *Action taken / Service offered (accepted)* | **Abuse substantiated** | *Abuse Not Substantiated* | *Abuse Partly Substantiated* | *Not Determined / Inconclusive* |
|---|---|---|---|---|
| Removed from Property or Service | 10 | 4 | 2 | 6 |
| Community Care Assessment | 18 | 9 | 7 | 13 |
| Civil Action | 1 | 0 | 0 | 0 |
| Application to Court of Protection | 5 | 0 | 0 | 2 |
| Application to change appointeeship | 1 | 0 | 0 | 1 |
| Referal for Advocacy scheme | 2 | 1 | 2 | 3 |
| Referral for Counseling / Training | 11 | 0 | 3 | 5 |
| Move / increase / different care | 32 | 3 | 12 | 17 |
| Management of access to finances | 6 | 2 | 3 | 7 |
| Guardianship / Use of Mental Health Act | 0 | 0 | 1 | 1 |
| Review of Self-Directed Support (IB) | 0 | 1 | 0 | 1 |
| Restriction / Management of access to person who caused the harm | 19 | 3 | 6 | 8 |
| Referral to MARAC | 5 | 1 | 1 | 1 |
| Increased Monitoring | 77 | 41 | 20 | 40 |
| No further action | 22 | 43 | 5 | 21 |
| Other | 43 | 22 | 16 | 20 |
| **Total** | **252** | **130** | **78** | **146** |

## *18) Summary of action taken for the person who caused alleged harm*

**Number of cases where action was taken/service offered for the person who caused alleged harm**

| *Action taken / Service offered (accepted)* | *Abuse Substantiated* | *Abuse Not Substantiated* | *Abuse Partly Substantiated* | *Not Determined / Inconclusive* |
|---|---|---|---|---|
| Removal from property or service | 22 | 2 | 2 | 0 |
| Action under the Mental Health Act | 2 | 0 | 4 | 1 |
| Community Care Assessment | 2 | 0 | 0 | 1 |
| Carers Assessment | 3 | 1 | 2 | 4 |
| Management of access to adult at risk | 15 | 3 | 3 | 9 |
| Criminal Prosecution / Formal Caution | 8 | 0 | 1 | 0 |
| Police Action | 29 | 0 | 3 | 4 |
| Disciplinary Action | 31 | 2 | 1 | 2 |
| Referral to ISA | 9 | 0 | 1 | 0 |
| Action by CQC | 1 | 0 | 0 | 1 |
| Action by Contracts Compliance | 5 | 2 | 1 | 2 |
| Referral to Court Mandated Treatment | 0 | 0 | 0 | 0 |
| Referral to registration body | 4 | 0 | 0 | 0 |
| Counselling / Training / Treatment | 23 | 7 | 3 | 4 |
| Continuing monitoring | 52 | 14 | 11 | 20 |
| Referral to MAPPA | 0 | 0 | 1 | 0 |
| Exoneration | 0 | 5 | 0 | 1 |
| No further action | 6 | 50 | 9 | 31 |
| Not known | 7 | 9 | 2 | 5 |
| Other | 0 | 0 | 0 | 0 |
| **Total** | **219** | **95** | **44** | **85** |