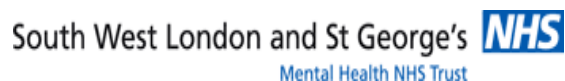


# RICHMOND UPON THAMES MULTI-AGENCY

## SAFEGUARDING ADULTS PARTNERSHIP BOARD

# ANNUAL REPORT

FOR THE YEAR 1<sup>st</sup> APRIL 2008 TO 31<sup>st</sup> MARCH 2009



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# Foreword

## Foreword from the Chairman of the Board

- 1.0 As Independent Chair of the London Borough of Richmond's Safeguarding Adults Partnership Board (SAPB), I would like to introduce the Annual Report for 2008/2009. The recruitment of an independent chair has been one of the actions taken following the challenging CSCI inspection report of services to older people and Safeguarding January 2008.
- 1.1 Building upon an improvement plan formulated as a response to the inspectors' findings and following a workshop the Board agreed a set of strategic partnerships, objectives and priorities for the year and formulated them into an action plan. I am pleased to report progress in all areas.
- 1.2 The SAPB is committed to a policy of close interagency partnership arrangements propagating zero tolerance of abuse or neglect of vulnerable adults linked to a wider concept of safeguarding linked to community safety and strategic partnership objectives, health and well being. The Board's aims include raising awareness of abuse, neglect or inadequate care of vulnerable adults through establishing and improving a commitment to preventative measures, strengthening partnerships and developing good inter agency practice across the borough, with all people who have contact with vulnerable adults.
- 1.3 This report describes some of the outcomes from the objectives set out by the SAPB for 2008/2009 and outcomes from additional factors that have emerged during the period.

*Russell Humphreys*  
*Independent Chairman of Richmond Safeguarding Adults Partnership Board*

## 1. Introduction

Safeguarding Adults prevention and response services are provided under the Department of Health guidance 'No Secrets' 2000, and the Association of Directors of Social Services 'Safeguarding Adults, a National Framework of Standards 2005', which underpin the Care Quality Commission (formerly Commission for Social Care and Inspection) framework for Inspecting Inter-Agency Safeguarding Adults services.

'No Secrets' delegated lead responsibility for coordinating multi-agency Safeguarding Adults activity to Local Authorities. However, the Safeguarding of Adults receives no specific or ring-fenced central government funding. Richmond Safeguarding Adults staffing, training and information services are therefore resourced through the commitment of partners. These include:

### The Safeguarding Adults Team

- Safeguarding Adults Strategic Lead/Manager
- Safeguarding Adults Operational Coordinator
- 3 Safeguarding Adults Administrators (1.5 LBRuT, 0.5 South West London and St George's Mental Health Trust)

### Learning and Development

- Provision of Multi-Agency Training through 40 courses, briefings and Conferences, commissioned by LBRuT.
- Attending national/regional events and training
- Individual agency commissioned training

## 2. What we have achieved in 2008/09

### 2.1 CSCI Inspection Improvement Plan

In response to the CSCI report of January 2008 the following have been achieved in the past year:-

- a) Revision and launch of the Inter-Agency Policy and procedures (November 2009)
- b) The implementation of the Safeguarding Adults Training Strategy, which has enabled us to target staff, for appropriate mandatory training and resources to raise awareness and better safeguarding practice to vulnerable adults
- c) Implementation of robust Safeguarding Adults case performance monitoring and audits to identify multi-agency areas of practice learning and concerns relating to cases, target learning, improvement and development needs. Methods include regular monitoring of process

compliance, quality monitoring and audits of case practice (internal and external and provider contract monitoring

- d) Improvements to the quality of support provided to vulnerable adults, who were referred regarding alleged abuse/neglect identified through case file audits.
- e) Improvements to how learning from monitoring contributes to better services to vulnerable adults
- f) Revision of SAPB governance and reporting arrangements
- g) Tangible and measurable improvements to safeguarding practice.

*(See Annexe 4 for CSCI Action Plan)*

### **3. SAPB Objectives**

The CSCI report provided a platform for additional objectives to be promoted by the SAPB themselves. These can be summarised as such:-

#### **3.1 To provide Strong Leadership and Partnership for safeguarding of Adults**

- a) The membership of the Board has been strengthened, and links with the Children's Board have been improved, with reciprocal representation on both boards.
- b) The Adult Social services processes have been embedded into the Boards policies and procedures, and this has been approved by the partners.
- c) Training has been provided for the Board and within the wider community.
- d) The terms of the four sub groups (Performance, Learning and Development, Best Practice and Information and Communication) have been reviewed and revised. The groups report regularly to the Safeguarding Adults Partnership Board. Reports are also made to Health and Wellbeing Partnership (HWBP), Community Safety Partnership (CSP), and Overview And Scrutiny Committee (O&S).
- e) The independent Chair has been recruited.

#### **3.2 Raise Awareness about Safeguarding adults**

- a) Awareness has been raised amongst professional and others in the community. This has been achieved through the website, leaflet distribution, improved discussions at provider forums, and the availability of accessible information for people with learning disability (PLD). There have also been policy and procedure awareness briefings with relevant professionals.

- b) A Richmond Adult & Community College (RACC) course for PLD has been operating and this will be extended to others.
- c) Dignity cards have been distributed throughout the community.
- d) A very successful conference highlighting the abuse of older people was held, with around 100 people attending. It is intended that this becomes an annual event.

### **3.3 Prevent abuse of adults wherever possible and promote self empowerment**

- a) Service users are being empowered through the increased awareness of abuse and the dignity in care scheme. Information has also been presented to the GP forum and the PCT.
- b) Employment monitoring and regular CRB checks have been introduced in service specification for new contracts and changes have been made to the contracts to more fully engage with the providers regarding safeguarding practice.
- c) Effective involvement has been established with MARAC (Multi Agency Risk Conference) to encourage self empowerment, where possible, in cases where domestic violence has occurred.
- d) A process has been agreed for monitoring and managing DOLS cases (Deprivation of Liberty Safeguards), whilst risk awareness work is being undertaken with the 'employers' in the field of SDS (Self Directed Support).
- e) The training programme has raised awareness and improved practice to improve performance of safeguarding practice and knowledge of policies, which have been drawn up have been put into practice.

### **3.4 Continually improve the Safeguarding Adults response by all partners.**

- a) There has been some development of individual agency procedures, and this will continue. The information systems have developed and a review of information sharing protocol initiated.
- b) Briefings to professionals ensured an understanding of the improved policy and procedures and have increased the involvement of the partners.
- c) One of the main outcomes of this is the increase reporting of alerts,(see 4.2).
- d) Internal and external case audits ensure appropriate implementation of and adherence to the inter agency policy and procedures. Feedback from the audits is disseminated amongst the teams and used to improve practice standards and the updating of training programmes as the needs

are identified. The Best Practice Group has a themed programme of topics to review and which will be the subject of their reports to the Board.

## 4. Learning from the Past to Inform the Future

4.1 Many of the past year's priorities remain relevant to 2009-2010 as the Board continues to build on the results already achieved:

- a) The Board will increase monitoring and analysis of IMCA (Independent Mental Capacity Advocates) use and DOLS cases for inter-agency learning and development of service provision.
- b) There is a need for a thorough review of multi-agency information sharing processes to ensure information about vulnerable adults and safeguarding activity can and will be made available as appropriate. Further development of inter-agency joint Protocols and for SAPB member agencies to demonstrate that they have appropriate procedures that complement the Inter-agency Procedures and record and report Safeguarding Adults activity to their own management Boards as well as the SAPB.
- c) Partners will be encouraged to undertake Risk Management of the SAPB's and their own organization's capacity to deliver the Action Plan, for targeting of Safeguarding Adults priorities.
- d) A review of Voluntary/Private sector representation will be undertaken to ensure there is improved involvement and effective systems for accountability and feedback to and from the SAPB to the forums being represented.
- e) The Board will review how users/carers views are informing the Board and how it learns from existing local good practice. The viability of inviting a Service User representative (via CVS) to join the Board will be explored, along with other methods of involving community networks.
- f) The Board will continue to pursue membership from the Crown Prosecution Service and Probation Service to promote joint working and increased understanding of Safeguarding Adults and crime.
- g) The Board will review the Terms of Reference for the Board and the current sub groups to ensure the structure is appropriate to deliver the next year's priorities/Action Plan, and review member commitment.
- h) The new role of Independent Chair will be clarified and developed
- i) A review will be undertaken of SAPB public communications ('Brand') to ensure effectiveness.
- j) The Board will review the training strategy and the SAPBs ability to deliver it's essential requirements with current resourcing. In addition to

commissioning and delivering training, a review of resourcing should also recognise:

- i) Analysis of current work within the strategy relating to continuing professional development needs, with ratification of the mapping exercise outcomes regarding Inter-agency training requirements.
  - ii) Ongoing need to review standards/quality and effective outcomes of training, including objectivity and quality assurance.
  - iii) Strengthen the link between training and case information for improved outcome measurement.
- k) The Board needs to continue to develop the Safeguarding Adults Quality Assurance role by implementing the recommendations in the 12 month Post Inspection review. This should include:
- Continuing to build links with service providers, CQC and Contract monitoring staff and use Concerns process information
  - Continue to liaise and learn from Complaints information
  - Better use of service user/carer feedback
  - Link all of these to identify poor practice and implement improvements.
- l) The Board needs to identify preventative support needs for avoidance of abuse/neglect for self- directed service users, including Individual budget holders and self-funders.
- m) The Board will consider how to maximise the role of Richmond LINK.
- n) The Board will increase community awareness of non-tolerance to abuse/neglect by improving publicity and review the effectiveness of the Dignity in Care campaign.

#### **4.2 Learning from Analysis of Alerts/Cases**

- a) The following paragraphs provide an overview of findings from analysis of cases reported during the year, with a summary of key messages. Detailed analysis has been undertaken and is informing ongoing targeted operational development.

As a result of the achievements described above, there has been an improvement in reporting and recording of abuse allegations by 90%:

Total number of Referrals 2008 –2009: 342  
Total Number of referrals 2007 – 2008: 180

- b) This is specifically attributed to:
- Improved recording of ‘alerts’ (not just cases investigated)
  - More effective partnership working at grass roots level
  - The raised awareness of Safeguarding Adults through publicity and briefings relating to the launch and implementation of the revised inter-agency policy & procedures
  - The extensive training programme, Elder Abuse conference and various presentations/briefings for multi-agency staff, carers and volunteers.

#### **4.3 Analysis of Service User Group 2008/2009**

- a) The number in this proportion of referrals relating to Older People has reduced during the year but is still the largest client group. This will be monitored to ensure it is a result of less abuse rather than less reporting.
- b) Mental Health (including Substance Misuse) bucks the national trend by being greater than the number of referrals from people with Learning Disability, this appears to be due to the relatively low numbers of referrals for PLD. Targetted improvement work is underway with the PLD Team to ensure any under-reporting is addressed.
- c) The incidences of sexual abuse remain relatively low. However, the Metropolitan Police Authority has expanded the Domestic Violence Board to include sexual abuse. The DVSB will be a multi agency organisation, which will be MPA led, meeting six times a year and will have links to all the boroughs.

#### **4.4 Case Analysis of Source of Referrals 2008-2009**

- a) 14% of total referrals do not record the source, indicating a training need
- b) There has been a slight increase in the referrals from Health partners, indicating increased awareness amongst health practitioners
- c) The greatest source of referrals remains from family and friends, though has reduced slightly from the previous year. Only 40% of total referrals were not from statutory or provider sources. Targets will be set for increased referrals from the community.

There is some evidence to indicate that sources are not always accurately recorded, with consequent under-representation of the number of referrals from the voluntary sector. This indicates a training need.

*(See Annexe 5 for detailed case analysis and Annexe 6 for detailed training analysis)*

## **5. Additional Objectives for 2009-2010**

As a result of case analysis and other learning from the review, there are additional priorities for 2009-2010 based on the learning from the Board's review and anticipation of future needs as described elsewhere in this report. The identified Priorities were:

- a) There is a need to 'get the message out' to the community at large. A communications strategy will be developed, with greater use of the website and the media.
- b) There is a need to develop the potential of the community at large as part of the safeguarding network, with related implications for communications

and training. This would also include exploring extra support for carers to help identify cases of abuse.

- c) A result of the recession may be the increase of financial abuse of vulnerable adults. There is a need to develop our links with financial institutions to address this subject.
- d) The collating of information could be improved further. Allied with this would be ensuring better access by partners to this information to make the information more relevant.
- e) The system of targeting and benchmarking needs to be further developed. This would also assist in the development of a robust skills training programme as the needs are identified.

### **5.1 Safeguarding Resources**

Due to the increase in the number of referrals received by the Integrated Health and Social Care Teams, the Safeguarding Adults Partnership Board identified the need for additional posts within the Safeguarding Adults Team. For the first 6 months of the year the coordinating function was provided through a full-time Safeguarding Adults Coordinator plus 2 full-time administrators. Following departure of one administrator and the coordinator, it was agreed that a new team structure would be piloted from January 2009. Full recruitment to the pilot posts was not completed before the end of March, so evaluation will be undertaken in 2009-2010. Posts include 2 fte Safeguarding Adults administrators (to include DOLS administration), 1fte Safeguarding Adults Co-ordinator and 0.5 fte Interim Safeguarding Adults Manager.

## **6. SAPB Work Plan**

The priorities and other activity for the coming year contained in this report were identified at an inter-agency review workshop to devise the SAPB Work Plan for 2009-2010. The work plan performance Indicators, time frames and allocated responsibility are currently being finalised, to enable tracking of progress and achievement over the year, (Appendix 3 Draft Plan). A public version of the Annual Report achievements and priorities for the coming year will be produced and made available on the Council's website.

## Conclusion

Much has been achieved in the past year. It is to the credit of all the partners, under the chairmanship of Jim Rogan, Assistant Director Commissioning Care Services, that such progress has been made. The need for good and regular communication between the partners is paramount and much of the ongoing work will be aimed at strengthening the relationships.

I am very aware that there is still a great deal of work to be done to ensure that all vulnerable adults are safeguarded, but recognise that the platform is in place upon which to build further.

Russell Humphreys  
(Independent Chair)

## Annexe 1

### Executive Summary

- We have ensured 342 vulnerable adults were safe or safer through assessing risk in response to alerts.
- We have improved the recognition and reporting of abuse of vulnerable adults, resulting in an increase of 90% in recording of alerts. This was achieved through revision and promotion of policy and procedure and by an extensive inter-agency training programme to staff, carers and volunteers.
- We have improved accountability and leadership to the highest levels, and increased resources to respond to Safeguarding Adults and Mental Capacity Act requirements for better preventative and responsive services in the future.
- We have improved inter-agency liaison for better prevention and outcomes for victims of abuse, including reciprocal representation with the Local Safeguarding Children's Board and greater involvement with voluntary and private sectors.

These are described in more detail throughout the report.

## Annexe 2

### Membership of the Safeguarding Adults Partnership Board

As part of the improvements to Governance arrangements initiated in early 2008, SAPB representation has expanded to include the following partner agencies.

London Borough of Richmond upon Thames:

- Dignity in Care Champion Councillor
- Assistant Director, Adult and Community Services
- Assistant Director, Specialist Children's Services
- Principal Manager, Community Services
- Principal Manager, Performance & Quality Assurance
- Safeguarding Adults Strategic Manager and Coordinator
- Head of Organisational Development
- Principal Manager, People with a Learning Disability.
- Head of Care Provision
- Head of Housing Operations
- Community Safety Partnership Manager

Richmond Housing Partnership

South-West London & St George's NHS Mental Health Trust

Community Safety Unit, Richmond Police

Richmond Primary Care Trust

Richmond Adult & Community College

Richmond Crossroads

Richmond Age Concern

CORLD

CSCI/CQC

Nursing and Residential Care Provider Forum Representative (Richmond Churches Housing Trust)

Domiciliary Care Provider Forum Representative (ENARA)

## Annexe 3

### **Board Leadership Structure**

The Assistant Director of Adult Social Care Services chaired the Inter-Agency Board to the end of the year, with successful recruitment to a new Independent Chair in February for the coming year. The Board delivered the Action Plan through 4 sub groups comprised of representatives from the membership agencies:

- Performance
- Learning & Development (Training)
- Best Practice (Manager meetings/practitioner mtgs)
- Information and Communication

## Annexe 4

### SAPB WORK PLAN 2009/2010 and Beyond

#### Strategic Objective 1: Provide strong Leadership and Partnership for Safeguarding of Adults

ref	Objective/Target	Action / performance indicator
1.1	Set and monitor clear direction for Safeguarding Adults activity based on local and national lessons.	<ol style="list-style-type: none"> <li>1. Clarify the role and responsibilities of the Independent Chair</li> <li>2. Implement the revised Performance Framework to ensure a 'learning loop' which absorbs lessons from all sources and implements them for continuous improvement.</li> </ol>
1.2	Improve inter-agency membership of SAPB to ensure widest influence.	<ol style="list-style-type: none"> <li>1. Pursue Crown Prosecution Service and Probation Services membership to the Board.</li> <li>2. Involve wider community through CSV or similarly representative organisations</li> <li>3. Review /refresh development needs of SAPB members</li> <li>4. Build Partnership commitment e.g. participation, resource identification</li> </ol>
1.3	Review Sub-Groups	<ol style="list-style-type: none"> <li>1. Review Terms of Reference and appropriate Inter-Agency membership of Sub Groups to ensure translation of strategic PI's into operational tasks and effective delivery of the SAPB Plan, e.g. to.</li> <li>2. Work programmes of Sub-Groups to be agreed and monitored by SAPB (to deliver this Action Plan).</li> </ol>
1.4	Strengthen links with borough-wide strategic groups	<ol style="list-style-type: none"> <li>1. Build on reporting relationship with CSP to obtain broader understanding of links between Safeguarding Adults and safety, for closer strategic and operational partnership working.</li> <li>2. Continue to build Inter-agency liaison structures to enable improved information-sharing, SA awareness raising and how best to engage partners and others.</li> </ol>
1.5	Improve clarity about SA governance arrangements	<ol style="list-style-type: none"> <li>1. Ensure all partners fully understand SA governance and delivery (Inter-Agency Policy &amp; Procedure) requirements, and have effective governance arrangements within their own agencies to complement and reinforce the Inter-Agency Policy and Procedure.</li> <li>2. Continue to improve shared understanding and reporting of clinical governance requirements between Trusts and SAPB.</li> </ol>

## Strategic Objective 2: Raise awareness about Safeguarding Adults

ref	Target	Action
2.1	Promote inter-agency and community awareness about Safeguarding Adults.	<p>Develop a SA Communications Strategy as a matter of urgency:</p> <ol style="list-style-type: none"> <li>1. Identify communication needs (including broader banner of 'community safety'), and maximise use of media opportunities for campaigns with partners by developing a schedule of activity etc, including promotion of new 'hotline' Poster, elder abuse week, Dignity etc.</li> <li>2. Develop the SA webpage, targeting to both professionals and wider community</li> <li>3. Develop an inter-agency newsletter/information bulletin, (signposting to website) that promotes national and local best practice/future developments (eg disseminate learning from Best Practice group)</li> <li>4. Produce appropriately accessible information materials for wide community use, targeting 'at risk' groups (see Strat obj 3 &amp; 4)</li> <li>5. Produce a Toolkit of 'user friendly' guides targeted to practitioners, advocates roles etc about SA (use Children's safeguarding model)</li> <li>6. Devise preventative literature e.g. handbook to advise individuals how to avoid, recognise thresholds/ escalation and where to seek help etc.</li> </ol>
2.2	Promote SA Community of Practice and improved inter-agency liaison	<ol style="list-style-type: none"> <li>1. Promote development of a SA practitioner Champions scheme within all partners agencies (as appropriate to size). across partner agencies</li> <li>2. Establish an Inter-Agency Champions Forum for continuing professional development of all agency champions and to enable pro-active information-sharing about SA, seeking advice, promoting SA awareness and how best to engage partners and others.</li> <li>3. Hold a borough Conference on Safeguarding Adults.</li> </ol>

**Strategic Objective 3: Prevent abuse of adults wherever possible and promote self-empowerment**

ref	Target	Action
31	<p>Develop a SA Prevention strategy</p> <p>a) Community Wide</p> <p>b) For professionals including Res/Dom Providers</p> <p>c) Embracing different risks posed by Personalisation and empowerment of service users</p>	<p>Develop a coordinated programme of activity to include:</p> <ol style="list-style-type: none"> <li>1. Maximise opportunities for linking to other strategic borough/agency initiatives and strategies e.g. CSP over Financial Abuse issues, Carers Strategy, Older People Strategy, Dementia Strategy, Dignity in Care.</li> <li>2. Use outcomes of case analysis and research from all sources (including QA 'Concerns', national/local benchmarking data, borough profile BMER analysis) to identify targeted action to mitigate against causes of abuse e.g. Information needs, training needs, partnership working to prevent: <ul style="list-style-type: none"> <li>• Financial abuse (e.g. work with local financial institutions, training, information)</li> <li>• Under reporting (e.g. raised awareness of importance through training)</li> <li>• Poor practice (e.g. training/information)</li> <li>• Under-representation e.g. BMER (e.g. work with community/rep/faith groups)</li> <li>• Recognition of thresholds of abuse, (e.g. training, awareness training).</li> <li>• Neglect (e.g. training, awareness raising)</li> <li>• Family/friends as perpetrators (e.g. training, awareness raising)</li> </ul> </li> <li>3. Continue to seek greater engagement with Primary Care staff and independent health practitioners, particularly GP's.</li> <li>4. Monitor MCA/DOLS cases and ensure learning is shared.</li> <li>5. Contribute to personalisation developments by ensuring information about risks associated with empowerment/choice is available to service users and carers before self-assessment to empower them to seek advice and/or advocacy at the earliest opportunity, and that training is available for individual budget holders/self funders to understand different responsibilities/risks, and personal assistants/carers to ensure standards of care.</li> <li>6. Ensure guidance materials and training of professionals for risk assessments and Personal Programme Planning is appropriate.</li> <li>7. Build links with community based service users groups.</li> <li>8. Build stronger Safeguarding Adults advisory service to Private and Voluntary providers.</li> </ol>
3.2	<p>Ensure Inter-Agency and individual agency policy and procedure does not inadvertently disadvantage vulnerable Adults</p>	<ol style="list-style-type: none"> <li>1. Undertake an Equality Impact Assessment of the Policy and Procedure, involving service users and carers, particularly when addressing any requirements following outcomes of No Secrets Review and Pan London Procedures.</li> </ol>

**Strategic Objective 4: Continually improve the Safeguarding Adults response by partner agencies**

ref	Target	Action
4.1	Ensure Quality Assurance and Quality Control	<p>Implement revised Multi-Agency Performance Management Framework, incorporating MCA/DOLS and from 1/10/09 new DH PI's:</p> <ol style="list-style-type: none"> <li>1. Each agency to demonstrate that it has its own internal SA Procedures, monitoring systems and learning loop.</li> <li>2. Ensure evidence that learning from all sources has led to changes in practice.</li> <li>3. Ensure formalised route for user feedback and involvement in improvements, including ensuring response to alleged victims is appropriate (monitoring use of Advocates as well as IMCA's) by consistent implementation of procedures across partner agencies)</li> <li>4. Improve quality of information for reporting, through implementation of revised IT system and training/guidance to support it.</li> <li>5. Continue to monitor compliance to Inter-Agency Policy and Procedures, and demonstrate remedial action where required.</li> <li>6. Continue to monitor quality of training and ensure effective outcome measurement of practice improvement.</li> </ol>
4.2	Be pro-active in response to national developments and innovation	<ol style="list-style-type: none"> <li>1. Review/revise Inter-Agency Policy and Procedure and revise practice to integrate key messages from No Secrets Review and Pan London Procedures.</li> <li>2. Revise recording and reporting in anticipation of new DH PI's (from 1/10/09)</li> <li>3. Identify research, practice etc for dissemination through Communications strategy (see Obj 2) e.g. bulletins, web page, training/briefings, Champions/Best Practice discussions.</li> </ol>
4.3	Ensure continuing professional development of Safeguarding Adults practice and maximisation of opportunities	<p>Review SA Learning &amp; Development Strategy to ensure it meets future needs:</p> <ol style="list-style-type: none"> <li>1. Clarify Inter-Agency training standards and coordinate monitoring of all partners (and zero rated homes) SA related training to enable improved targeting, maximise opportunities, promote cross-fertilization and ensure consistency in good practice/messages.</li> <li>2. Develop Inter-agency Champions CPS programme.</li> <li>3. Continue to develop/revise targeted skills based training for prevention and response, including issues emerging from monitoring analysis and other sources of learning e.g. thresholds of abuse, MCA/DOLS.</li> <li>4. Continue to seek greater engagement with GP's and other Primary Care practitioners.</li> </ol>

## Annexe 5

### CSCI Improvement Action Plan

**The Council and its partners should implement robust performance arrangements and quality assurance arrangements so that:**

- **Compliance with procedures is ensured**
- **Minimum standards of practice and management are assured and**
- **Performance is improved**

Action	Timescale
Case file audit tool developed in March 2008 which references standards in revised policy & procedures. Cases audited across all client groups by Senior /Team Managers and the Safeguarding Coordinator.	Audits started March 2008 & completed each month
External auditor commissioned to undertake eight case audits, three times a year. The auditor will use the same case file audit tool and will audit cases selected by Safeguarding Coordinator, including some cases that have already been audited. The external auditor will report findings to the Safe-guarding Best Practice Group immediately following the audit	External audit to commence 9 June 2008 and October & February each year.
Results of all audits discussed monthly at Safeguarding Best Practice group. Findings are cascaded to teams through team meetings. A summary report from the group presented at Safeguarding Board every two months showing impact of audits on training, procedures and partnership working and details of non compliance.	First Best Practice meeting March 2008 – meetings take place monthly
Non compliance dealt with in the following ways: LBRuT staff – actions followed up by Team Manager with the individual. Safeguarding Coordinator produces monthly report for each team identifying improvement actions required, actions completed and progress chases with Team Manager.	From May 2008 - ongoing
Partner staff - Safeguarding Coordinator provides detailed report for each organisation each month and progress chases with the partner Quality Assurance representative	From July 2008 – ongoing
Contracted providers – Safeguarding Coordinator provides monthly issues to Quality Assurance Manager. Non compliance feeds into provider risk assessment (see 9.3)	From May 2008 - ongoing
Supervision checklist and guidance developed March 2008 which align to the case file audit & safeguarding competencies. Where poor performance or non-compliance identified by LBRuT staff an individual action plan will be put in place and monitored monthly through supervision and further audit of practice after 3 months.	From April 2008 check-list used in every supervision session
Chronology of key events developed in April 2008 for LBRuT staff to use as recording tool in all safeguarding cases. The chronology aligns to standards in	From May 2008 chronology used for all

Action	Timescale
case file audit tool and is checked in each case file audit.	cases
Safeguarding Coordinator ensures tracking of all safeguarding cases to comply with timescales for sending of minutes/actions and delivering of actions following safeguarding meetings. Reporting of timescale compliance to AD Commissioning Care Services and Principal Managers Community Services on a monthly basis.	From April 2008 report provided each month
Safeguarding Board to establish LBRUT Quality Assurance sub group, to agree organisational standards for Board members. Standards taken from <i>ADASS Best Practice National Framework of Standards for good practice</i> .	Partners agreed to standards at Board April 2008 - completed
Quality Assurance sub group expanded on multi agency basis with lead identified for each partner organisation who will take responsibility for: Ensuring ADASS Best Practice standards are in place All issues of non compliance with policy and procedures are addressed Ensuring monitoring systems are in place to ensure compliance with policy and procedures and are reported back to the QA sub group Terms of Reference and work programme 08/09 to be agreed at meeting in May 2008 and ratified by the Safeguarding Board at the Planning day in June 2008	First meeting May 2008 – meetings to be held bi monthly
Analysis of safeguarding referrals presented to Safeguarding Board identifying trends, reasons for abuse, outcomes etc. Analysis to inform <ul style="list-style-type: none"> <li>Monthly audit of cases</li> <li>Non compliance of procedures</li> <li>Changes to procedures</li> <li>Training needs</li> <li>Contract monitoring</li> <li>Any actions to be taken forward with /by partners.</li> </ul> Overall, the analysis will inform the work of the Safeguarding Coordinator, the Board and will identify priorities for action to be included in the annual safeguarding plan.	First report presented February 2008 and to each safeguarding Board – ongoing

**2. The Council and partners should devise and implement a robust, skills based, specialist training programme for staff from all agencies involved in safeguarding procedures**

Action	Timescale
Multi-agency Training Strategy agreed by Safeguarding Board in February 2008 and training sub group established. The strategy specifies levels of competencies and the training that staff from different agencies and at different levels will require.	Feb 2008 - completed
Strategy requires mandatory awareness training for all staff with direct service user contact; advanced training for 'investigators' and Chairs. Also mandatory refresher training for staff undertaking investigations that were trained over 3 years. LBRuT staff instructed that only staff with appropriate training can undertake safeguarding investigations	April 2008

Action	Timescale
From the end of October 2008 only staff having completed advanced training can chair meetings. In interim the most experienced staff will be selected to chair.	October 2008
Competencies developed to link with the new policy and procedures to ensure that staff are suitably equipped to conduct an investigation or chair meetings. To be addressed through supervision and appraisal and linked to the recruitment and retention scheme.	Competency in place June 2008
Training strategy action plan developed by LBRuT staff and presented to Safeguarding Board in April 2008 for sign up by partner agencies.	Sign up by Board April 2008 – completed
Safeguarding Board partners to identify leads for training sub group to develop <i>multi agency</i> action plan to deliver the training strategy. Leads to take responsibility for ensuring all relevant staff are trained; the set up and delivery of multi agency courses and appropriate monitoring arrangements are in place.	Meeting May 2008 - meetings held every two months
Audit of LBRuT Adult Social Services staff training records to confirm attendance at appropriate courses and to identify staff not trained.	Audit completed January 2008
All staff undertaking safeguarding investigations booked on training courses before the end of March 2008.	All staff attended courses prior to 31/3/08 - completed
Database set up to track safeguarding training requirements for all staff in Adult Social Services – identifying staff that have not had appropriate training to inform courses required for 08/09.	Database set up March 2008 - completed
Training records from partner agencies collected, including any training delivered by LBRuT. Sub group to report % staff trained across partner agencies to Safeguarding Board in June 2008.	Report to Board in June 2008 & future meetings

### 3. The Adult Safeguarding Board should strengthen the commitments within the inter-agency adult safeguarding procedures and implement a structured system of compliance monitoring

Action	Timescale
Policy and procedures revised in accordance with ADASS guidance. These state the standards and responsibilities to be met by all partners, with some specific to an organisation and some 'overarching'.	Revision completed April 2008
Policy and procedures distributed to Safeguarding Board partners for consultation. Partners to agree revised policy in their organisations with feedback at Quality Assurance sub group and final agreement at the Safeguarding Board Planning day on 17 <sup>th</sup> June 2008.	To be agreed 17 <sup>th</sup> June 2008
The council to request formal endorsement of multi agency procedures from senior officers in key partner organisations.	July 2008
Policy and procedures to be launched at the Elder Abuse day on 20 <sup>th</sup> June and implemented end of July 2008.	July 2008
The Safeguarding Board will monitor partner compliance to the policy and procedures through reporting of all the sub groups to the Board at each meeting.	From August 2008 - ongoing

Action	Timescale
Serious Case Review protocol agreed at Safeguarding Board meeting April. Final sign off pending comments from Coroner's office and the police.	May 2008
Other protocols and commitments of inter-agency partners to be identified at Board Planning day 17 <sup>th</sup> June	June 2008
Briefings to inform LBRuT staff and partners of new policy and procedures	June/July 2008
Framework system updated to support revised Safeguarding procedure	July 2008

**4. The Adult Safeguarding Board should strengthen its leadership role to ensure the proper level of engagement of partner agencies so that safeguarding activity is supported and performance managed by all agencies**

Action	Timescale
The safeguarding board will lead/drive the improvement in policy procedures and practice to bring about improved safety of vulnerable adults, by: Reviewing Safeguarding Board membership to ensure senior representation from key partners as identified in ADASS best practice guidance	June 2008
Providing quarterly reports to Health & Wellbeing and Community Safety Partnerships and annual report to Overview and Scrutiny. Reports will highlight partner compliance, benchmark performance and will identify key concerns to be considered by the Partnerships and Committee.	From July 2008 - ongoing
Independent chairing of Safeguarding Board to be considered by Health & Wellbeing Partnership	June 2008
Presenting updates/monitoring of the Inspection Action Plan to Community Safety Partnerships and Overview & Scrutiny twice yearly and to Directorate Management Team quarterly. Monitoring will identify: <ul style="list-style-type: none"> <li>• Actions completed</li> <li>• Actions on target to meet timescale</li> <li>• Target date missed or likely to be missed</li> </ul> Report will also include risk assessment of targets likely to be missed with further actions identified to mitigate risks	From July 2008 - ongoing
Council's Corporate Plan updated to include expectation of raising awareness of safeguarding adults	

## Annexe 6

### Detailed Case Analysis

#### Analysis of Alerts received 2008/2009

The following data is an analysis of safeguarding adults referrals made from 1<sup>st</sup> April 2008 to 31<sup>st</sup> March 2009.

#### Total number of Alerts/Referrals

Total referrals 2008-2009 : 342  
Total referrals 2007-2008 : 180

Increase of 90%

#### Number of Referrals – by Service User Group

##### Number of Referrals by service user group in 2008/09 by Quarter

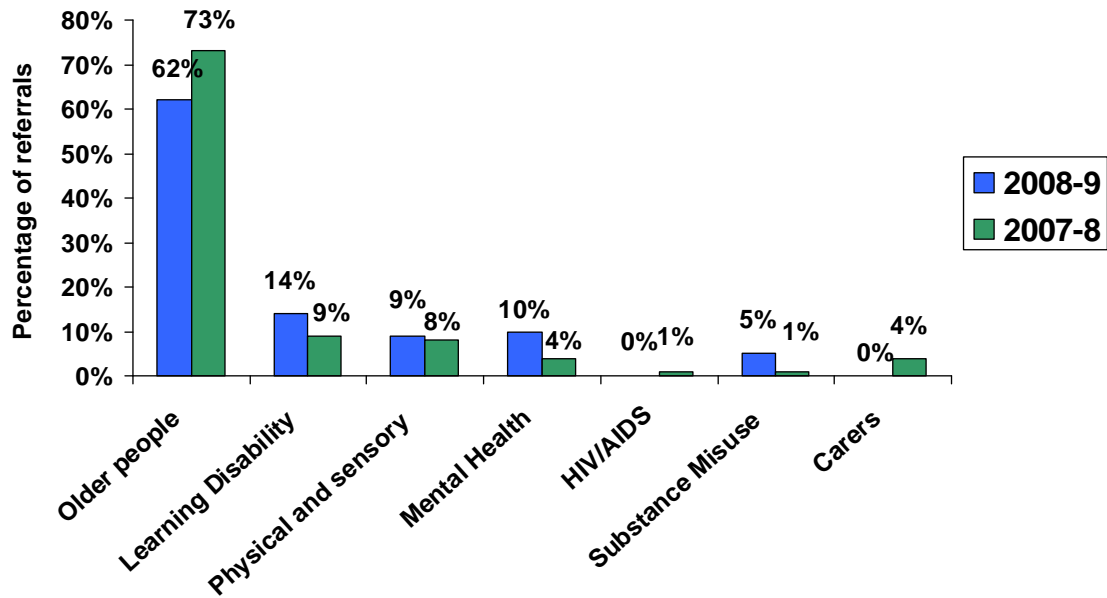
Service User Group	Qtr 4		Qtr 3		Qtr 2		Qtr 1	
	No	%	No	%	No	%	No	%
Older People	36	42%	49	55%	47	61%	72	79%
Learning Disability	19	22%	9	10%	14	18%	4	4%
Physical & Sensory	9	11%	6	7%	8	10%	8	9%
Mental Health	15	18%	18	20%	4	5%	4	4%
HIV/AIDS	0	0%	0	0%	0	0%	0	0%
Substance Misuse	6	7%	6	7%	4	5%	3	3%
Carers	0	0%	1	1%	0	0%	0	0%
<b>Total</b>	<b>85</b>		<b>89</b>		<b>77</b>		<b>91</b>	

##### Comparison of Referrals by service user group 2008/09 to 2007/08

Service User Group	2008/09		2007/08	
	No	%	No	%
Older People	204	60%	131	72.8%
Learning Disability	46	13%	17	9.4%
Physical & Sensory	31	9%	14	7.8%
Mental Health	41	12%	7	3.9%
HIV/AIDS	0	0%	2	1.1%
Substance Misuse	19	6%	1	0.6%
Carers	1	*	8	4.4%
<b>Total</b>	<b>342</b>		<b>180</b>	

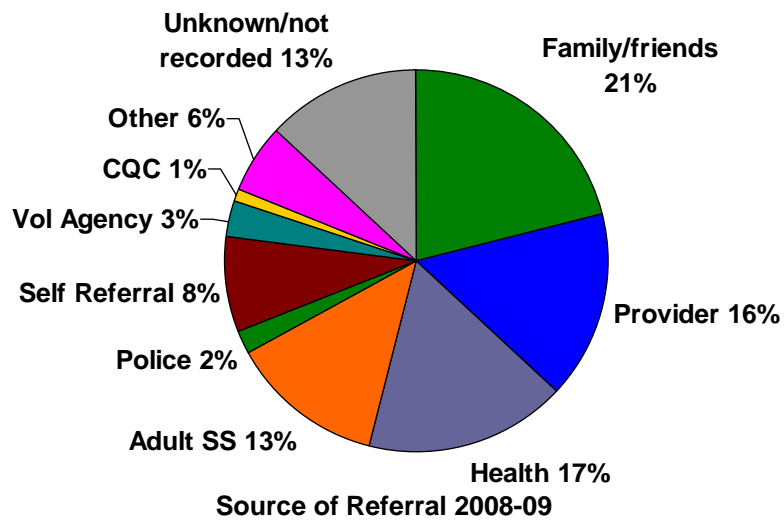
\* This indicates where a percentage is less than 1%

## Referral by User Group Yearly Comparison



## Source of Referrals

Source of referrals

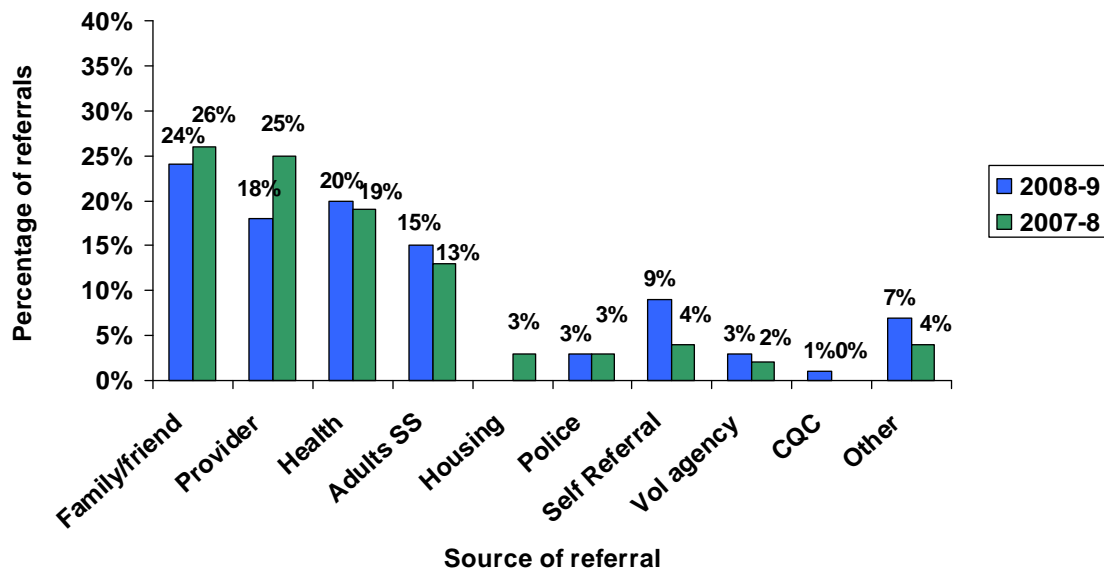


## Referrals by Referrer 2008/09 to 2007/08

Referrer	April 2008-March 2009%	April 2007- March 2008%
	%	%
Family/Friend	24%	25.7%
Provider	18%	25.0%
Health	20%	18.9%
Adults SS	15%	13.3%
Housing	*	3.3%
Police	3%	3.3%
Self Referral	9%	3.9%
Vol agency	3%	2.2%
CQC	1%	0%
Other	7%	4.4.%

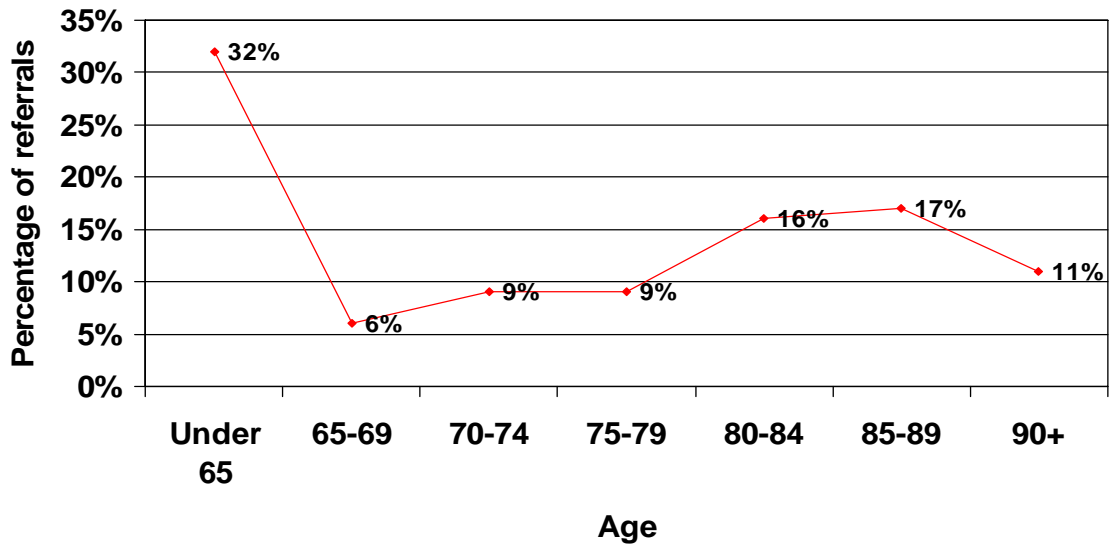
\* This indicates where a percentage is less than 1%

## Source of Referral



## Who are the referred people?

### Age Breakdown



### Ethnicity of Alerts/Referrals

Year	% 08/09	% 07/08
BMER	8%	5.9%
White	85%	94.1%

### Gender of Alert/Referrals

Year	% 08/09	% 07/08
Female	61%	66.1%
Male	39%	33.9%

## Who are the alleged perpetrators?

### Alleged Perpetrator 2008-09

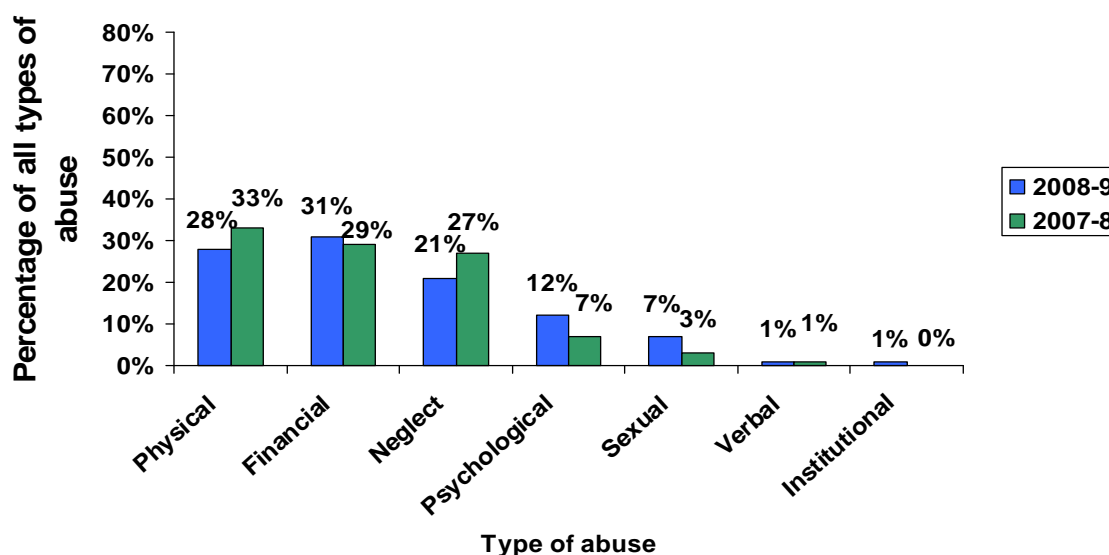
#### Referrals by perpetrator 2008/09 to 2007/08

Perpetrator	April 2008- March 2009	April 2007- March 2008
	%	%
Paid Carer	33%	49.7%
Family/Friend	48%	31.6%
Stranger	5%	8.4%
Other Service Users	4%	5.1%
Other professional	7%	4.5%
Other	3%	0.7%

\*There were 2 service users who were safeguarded against more than 2 different types of perpetrators and 1 service user who was safeguarded against 3 different types of service user

## What were the types of abuse?

Analysis of types of abuse



## Where did abuse take place?

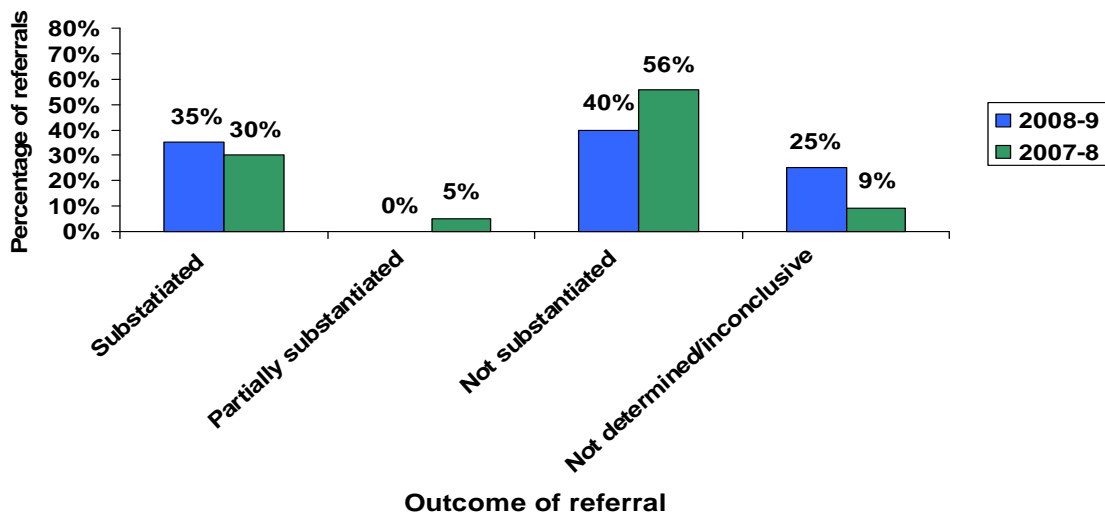
Referrals by location of abuse 2008/09 to 2007/08

Location of suspected abuse	April 2008- March 2009	April 2007- March 2008
	%	%
Own Home	65%	61.9%
Residential Care Home	13%	21.9%
Nursing Care Home	10%	10.6%
Hospital	2%	2.5%
Day Centre	1%	1.3%
Alleged Perpetrator Home	3%	0.6%
Public Place	2%	0.6%
Sheltered Accommodation	3%	0.6%
Work	1%	0%
Supported accommodation	*	0%
<b>Total recorded</b>		
Unknown/not recorded		
<b>Total</b>		

\* This indicates where a percentage is less than 1%

## What was the outcome of the referrals?

### Analysis of allegation outcomes



## Perpetrator

### Analysis of allegation outcomes cases by perpetrator type

Perpetrator Type	Substantiated Cases	Substantiated cases
	% 08-09	% 07-08
Paid Carer	17%	33.8
Relative/Friend	67%	22.5
Stranger	17%	69.2
Other Service User	0%	62.5
Other Professional	0%	27.1
Other	0%	
<b>Total recorded</b>		
Not Recorded		
<b>Total</b>		

\*There were 2 service users who were safeguarded against more than 2 different types of perpetrators and 1 service user who was safeguarded against 3 different types of service user

## Annexe 7

Multi-Agency Safeguarding Adults Training 2008-2009

(Commissioned and delivered by LBRuT)

	No of courses	LBRuT	P&V other	HC	RTPCT	SWLSTG MHT	KPCT	Police	Total
Elder abuse conference (.5)	1	39	25	3	5	3		3	78
SA Inter-agency Policy Launch	1	13	10	6			2		31
SA Policy Launch briefing	2	72							72
SA - Advanced (2)	4	40	4	1	8				53
SA - Foundation (.5)	16	43	126	25	30	2	1	3	230
SA - Foundation (.5)	3	60							60
SA - Foundation (.5)	2	46							46
SA - Minute taking	1	13							13
SA Criminal Investigations (.5)	3	28	17	2	1	1			49
SA Refresher for care managers	1	8							8
SA Role and Resp.	4	21	21	6	6	1	2		57
SA Chairing protection meetings	1	15			1				16
Supervisory training for Managers	1	13							13
Total no of courses	40								
Total no of staff									<b>726</b>
% attendance		53%	31%	6.25%	8.00%	0.75%	0.50%	0.50%	