



Safeguarding Adults Board Annual Report 2016 - 17

Safeguarding Adults Board

Barking & Dagenham

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Foreword by Sarah Baker, Independent Chair of the Barking and Dagenham Safeguarding Adult Board.

Welcome to the 2016/17 Annual Report of the Barking and Dagenham Safeguarding Adults Board (SAB). The Annual Report presents the work of the Safeguarding Adults Board as it works under the auspices of the Care Act 2014.

I have been the independent chair of London Borough Barking and Dagenham Safeguarding Adult Board since October 2014. This is a statutory post as set out in the Care Act 2014. My job is to hold agencies to account for the effective coordination of the commissioning and provision of services for adults, to ensure that adults at risk are safeguarded. I provide independent challenge so that each Board agency partner and their representatives are held to account.

To achieve this, I have quarterly governance meetings with the Leader of the Council, the Lead Member for Social Care and Health Integration, the Chief Executive of London Borough Barking and Dagenham and the Strategic Director of Service Development and Integration. I also have one to one meetings with the Strategic Lead officers for the statutory partner organisations on a regular basis. These meetings are effective in influencing the SAB agendas for successful delivery of the SAB business plan. Meetings are well attended by partners and the Lead Member for Social Care and Health Integration attends the SAB meetings so that she is informed and can provide effective challenge to Council officers.

My evaluation of the SAB business plan is that partners have successfully completed five of the eight priorities set out in the business plan, however there is more work to do against the remaining three priorities. At the same time, the SAB has been proactive in responding to emerging issues including the CQC inspections at BHRUT and NELFT and serious incidents in general practice.

I attend the Health and Wellbeing Board and have had the opportunity to contribute to debate and discussion to ensure safeguarding issues are considered with the wider health and social care agenda. I also presented the SAB Annual report for 2015/16.

I am also the independent chair of the Barking and Dagenham Safeguarding Children Board. This has provided the opportunity to consider safeguarding issues across adults' and children's services, including hoarding and associated fire and mental health issues. I use my knowledge from both boards to make links and find solutions for children and families. Examples of joint work include working with the fire brigade and workshops on hoarding.

The SAB evaluated itself against the Care Act 2014 and whilst progress has been made from last year's audit there is still work to do to ensure full compliance. Key areas of focus are:

- advocacy
- Mental Capacity Act and Deprivation of Liberty
- Making Safeguarding Personal, and
- information sharing.

The SAB has set up the Multi Agency Safeguarding Case File Audit group, inviting practitioners to present cases identifying best practice, safeguarding issues and areas for development. It was interesting to note that the areas for front line development mirrored those featuring in the Care Act Compliance audit as above.

This year the SAB has commissioned three Safeguarding Adult Reviews (SARs), one of which will not be completed until later in 2017. A more detailed account of the completed SARs is available at chapter 9. Themes arising from both completed SARs include discharge planning and application of the Mental Capacity Act. The SAB will be providing briefings for staff across the partnership and reports for completed SARs have been published on the SAB webpages of the London Borough of Barking and Dagenham website.

The Barking and Dagenham SAB is a multiagency partnership and is much more than the sum of its parts. Managers and front-line practitioners across the partnership all work extremely hard under significant resource pressures with some of the most vulnerable adults in Barking and Dagenham. There is always much work to do but I am confident that will continue to give the highest priority to safeguarding adults as already demonstrated through their commitment and attendance at SAB meetings, engagement in multi agency audit of practice, safeguarding adult reviews and SAB multi agency training.

The SAB partners have agreed the following priorities for next year:

- Making Safeguarding Personal
- Disseminate the Hoarding Policy
- Develop and embed the Performance and Quality Framework
- Increasing community awareness around safeguarding
- Enhance joint working with the CSP and LSCB
- Applying the Mental Capacity Act to practice.

I would like to thank all partners and front-line practitioners for their commitment to safeguarding adults in Barking and Dagenham.

R Sach Bever

Independent Chair of the Safeguarding Adults Board

The Care Act 2014 came into force on 1st April 2015. The Act introduced new requirements for safeguarding adults and the arrangements that each locality must have in place to ensure that vulnerable people are protected from risk, abuse or neglect. The Local Authority, Clinical Commissioning Groups and the Police are all statutory partners of the Safeguarding Adults Board (SAB) and other partners are involved via the committees and working groups.

The Care Act identifies six key principles that should underpin all safeguarding work. These are accountability, empowerment, protection, prevention, proportionality and partnership.



The SAB must publish an Annual Report each year as well as a Strategic Plan. In addition, the SAB has a statutory duty to carry out Safeguarding Adult Reviews (SARs) where an adult in the local authority area:

- has died as a result of abuse or risk (either known or suspected) and there are concerns that partner organisations could have worked together more effectively to protect that adult.
- has not died but the SAB knows or suspects that adult has experienced serious abuse or neglect.

The implementation of recommendations and action plans from a SAR must be reported in the Annual Report, including any decision not to implement any recommendation. Three SARs were commissioned during 2016/17 one of which will not be completed until later in 2017. An overview of the SARs is given in chapter 9.

This Annual Report of the Barking and Dagenham SAB looks back on the work undertaken by the SAB and its committees, throughout 2016/17 and provides an account of the work of the partnership including achievements, challenges and priorities for the coming year.

Over the past year partnership working, co-operation and involvement in adult safeguarding has been strengthened. This is evidenced through frontline engagement in learning events including the hoarding workshops, which has culminated in the development of a hoarding policy and the initiation of a Complex Case Panel.

All statutory partners make financial contributions to the Safeguarding Adults Board. For 2016/17 the partner contributions to the SAB were as follows:

CCG - £30,000

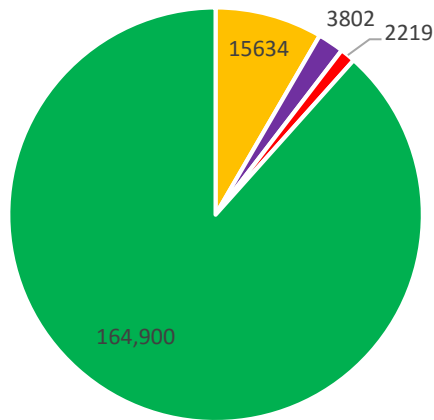
Police - £5,000

London Fire Brigade - £500

LBBB - £227,720 (including a Support Services budget of £164,900).

The following chart shows how the SAB budget has been spent in 2016/17. The majority of the budget covers support services including staffing costs (for the independent chair and the Safeguarding Adults Board Business and Policy Manager). The second largest spend is on Safeguarding Adult Reviews, followed by single agency reviews. The remaining spend enabled the board to deliver briefing events to share the learning from SARs and single agency reviews with front line practitioners and managers across the SAB partnership. These were very well attended and we reached out to around 170 professionals.

SAB Expenditure (£) 2016/17



- SARs
- Single Agency Reviews
- Learning events & meetings
- Support Services

Our Vision

Every adult living in the London Borough of Barking and Dagenham has the right to live in safety, free from fear of abuse or neglect. The Safeguarding Adults Board exists to make sure that organisations, people and local communities work together to prevent and stop the risk of abuse or neglect.

In the London Borough Barking and Dagenham we want to embed a stronger and safer culture that supports adults who are at risk of harm. We know that to achieve this we have to work in partnership with the people who use local services and with the wider local community. All agencies working with adults at risk have an essential role in recognising when these people may be in need of protection. Agencies also have a responsibility to work in partnership with adults at risk, their families, their carer(s) and each other. The introduction of the Care Act 2014 has brought in many changes in Adult Social Care Services. The Safeguarding Adults Board has a statutory duty to ensure it uses its powers to develop responsibility within the community for adults who need care and protection.

The prime focus of the work of the Safeguarding Adults Board is to ensure that safeguarding is consistently understood by anyone engaging with adults who may be at risk of or experiencing abuse or neglect, and that there is a common commitment to improving outcomes for them. This means ensuring the community has an understanding of how to support, protect and empower people at risk of harm. We want to develop and facilitate practice which puts individuals in control and generates a more person-centred approach and outcomes.

The Safeguarding Adults Board has developed a Strategic Plan which sets out how we will work together to safeguard adults at risk.

The Safeguarding Adults Board has a responsibility to:

- **protect** adults at risk
- **prevent** abuse occurring, and
- **respond** to concerns.

You may suspect that someone is at risk of harm because:

- you have a general concern about someone's well being
- you see or hear something which could put someone at risk
- someone tells you that something has happened or is happening to them which could put them or someone else at risk.

The Board and its Committees 4

The Barking and Dagenham Safeguarding Adults Board is made up of the following statutory partners:

- The Local Authority (representing Adult Social Care and Children's Services)
- The Borough Police
- The Clinical Commissioning Group (CCG).

Other members of the Board include:

- Chairs of the Committees
- Officer advisors.

In addition, the SAB may invite other organisations or individuals to attend and speak at the meetings where they have contributions to make.

The SAB has three standing committees, which are chaired by different partner organisations:

- The Performance and Assurance Committee (chaired by the Clinical Commissioning Group)
- The Safeguarding Adult Review Committee (chaired by the London Borough of Barking and Dagenham)
- Learning and Development Committee (chaired by North East London Foundation Trust).

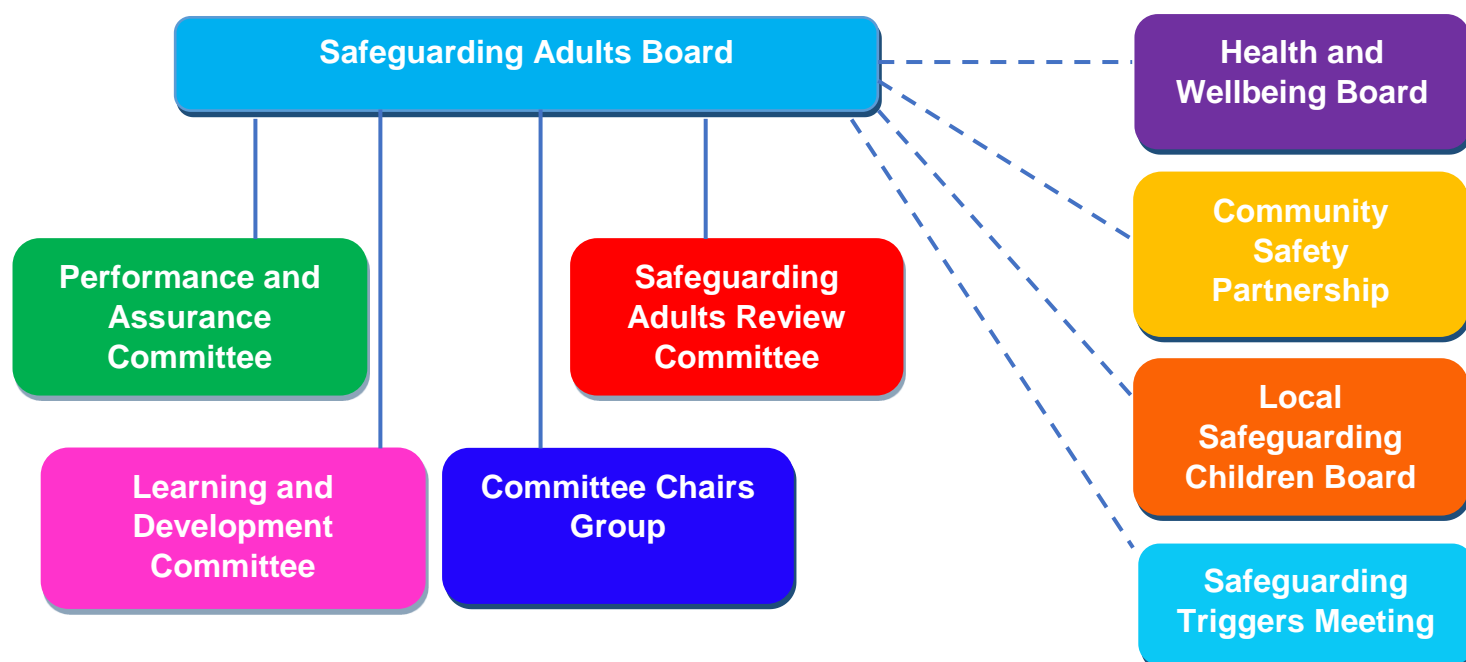
The Chair of each committee is responsible for:

- Developing a work programme which will be incorporated into and monitored through the SAB strategic plan.
- Resourcing the meetings of the committee.
- Reporting on the progress of the committee's work to the SAB and ensuring that the membership of the committee draws in the required experience.

The independent chair of the SAB meets quarterly with the committee chairs to provide a forum for reviewing progress of the work plans and to discuss and debate specific topics to progress their work.

Working groups have also been established by the SAB to undertake specific pieces of work on behalf of the board.

The Safeguarding Adult Board Structure



The independent chair is the chair of both the Barking and Dagenham Safeguarding Adults Board and the Safeguarding Children Board. This allows for opportunities to consider safeguarding adults and children at risk, and the issues affecting both.

The independent chair attends the Health and Wellbeing Board to allow for further consideration and debate regarding the issues of safeguarding within the agenda.

The independent chair meets quarterly for a *Triggers Meeting* with the Leader of the Council, the Lead Member for Social Care and Health Integration, the Chief Executive of the London Borough of Barking and Dagenham and the Deputy Chief Executive and Strategic Director for Service Development and Integration, to review performance data for adult social care, including workforce data and associated risks and mitigation. This allows for open debate, discussion, challenge and demonstrates a climate of openness and transparency.

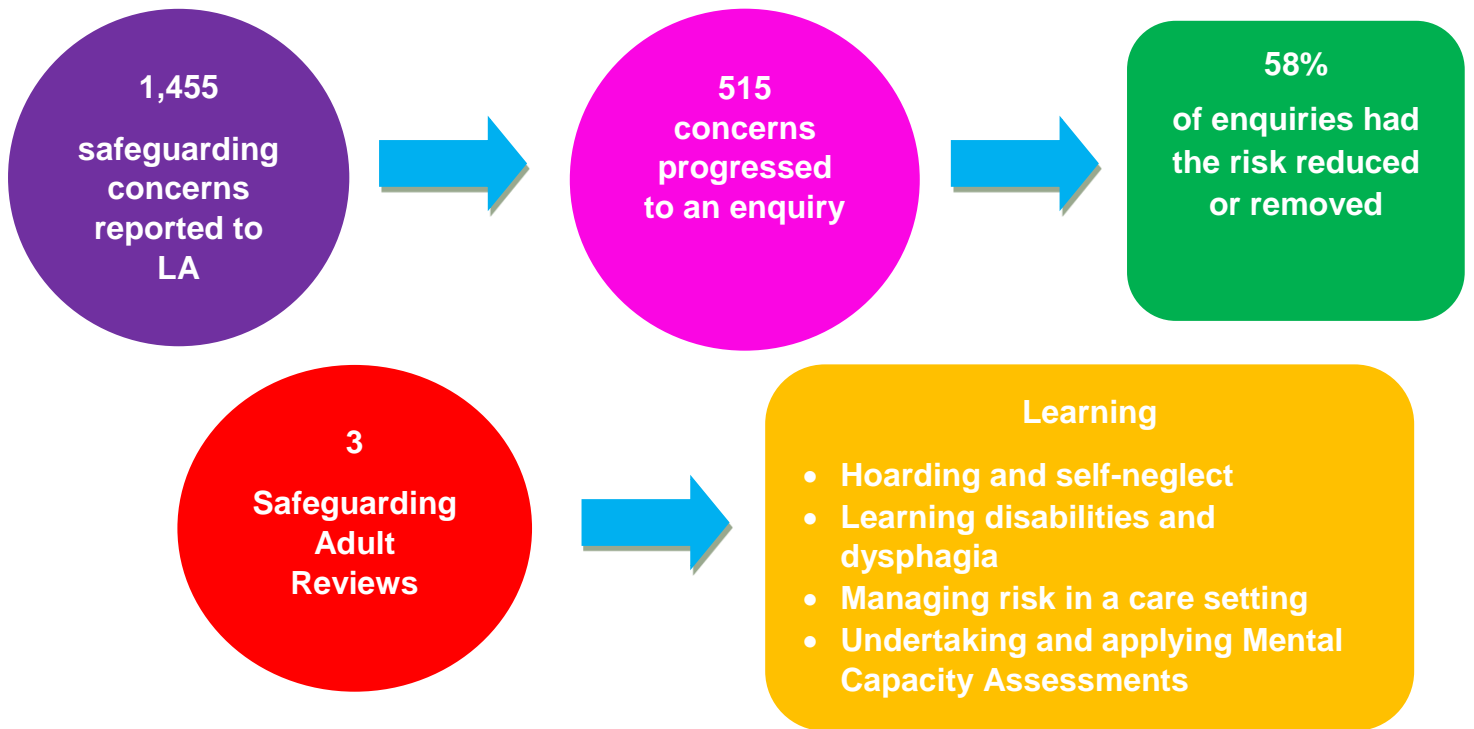
Partners' attendance at the SAB in 2016/17 was as follows:

Independent Chair	100%
London Borough of Barking and Dagenham	100%
Police	100%
Clinical Commissioning Group	100%

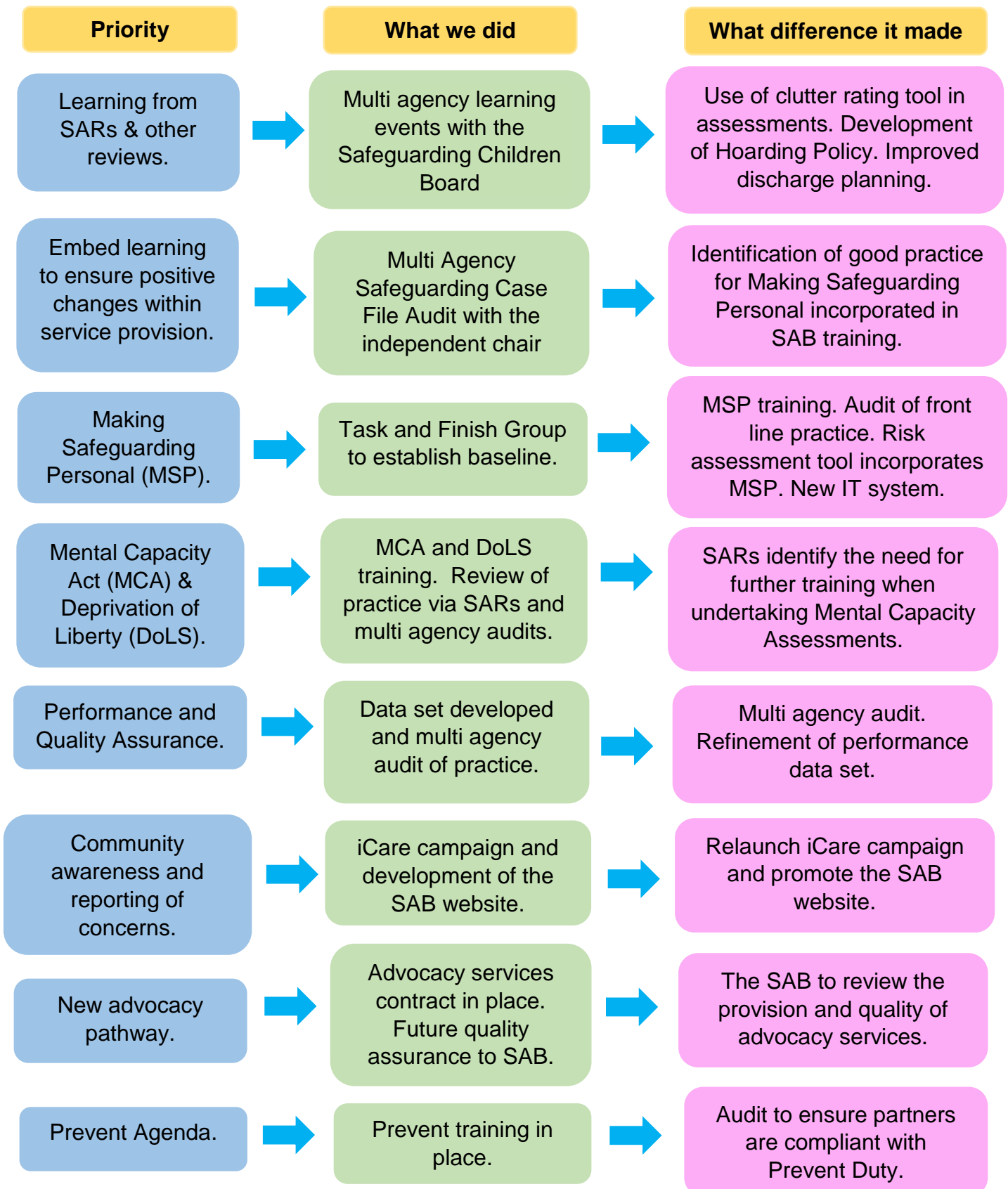
The board is supported by the Lead Member for Social Care and Health Integration as a participant observer. This enables Councillor colleagues to be kept up to date with safeguarding adult matters. In addition, the Committee Chairs and officer advisors also attend board meetings.

Safeguarding at a Glance

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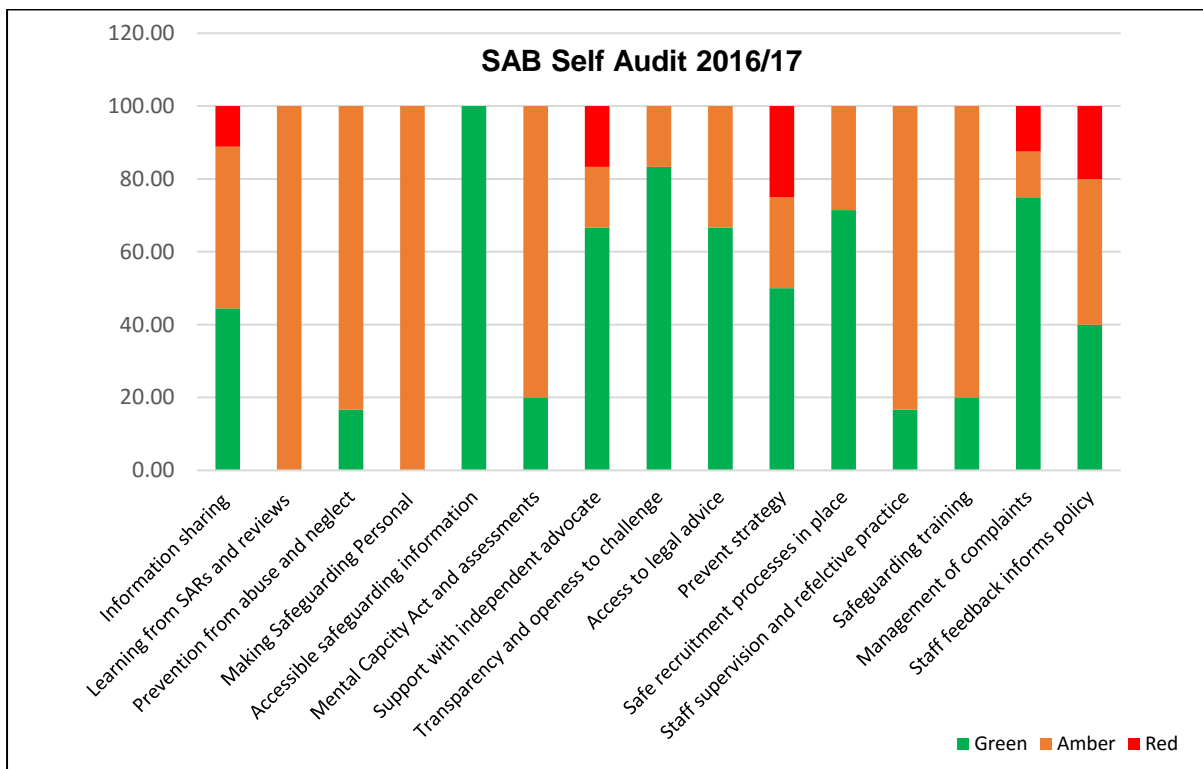
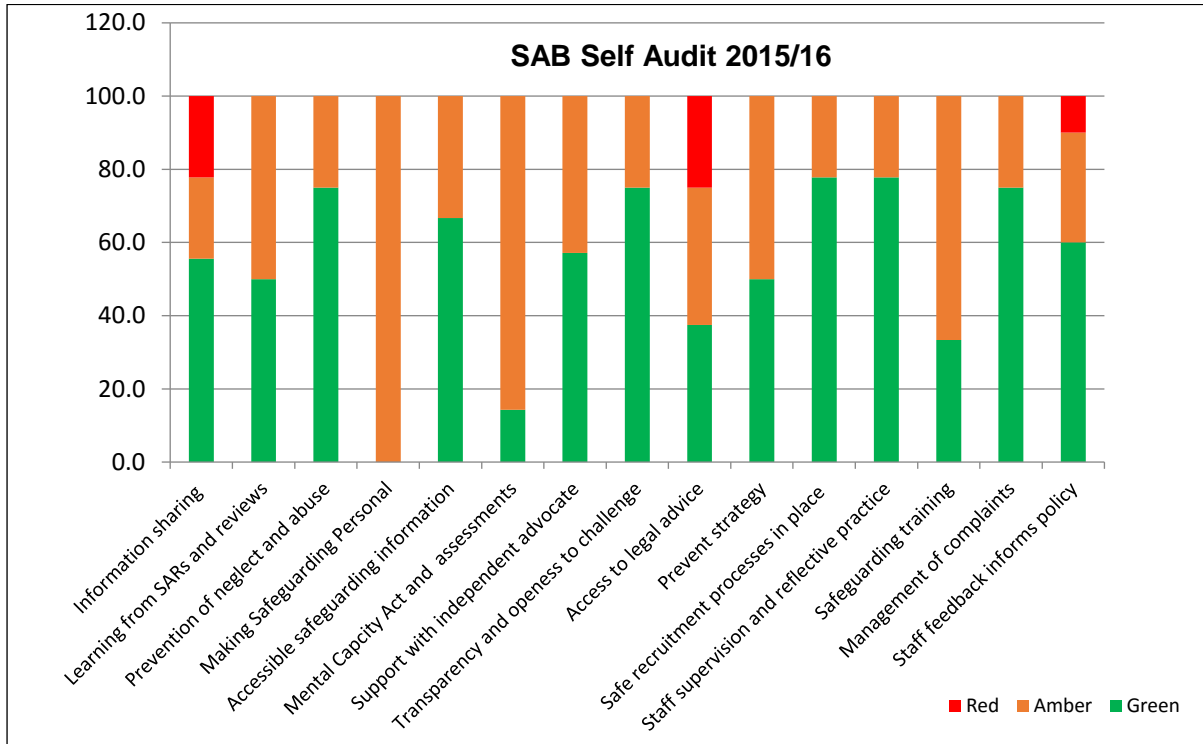


SAB Progress Against Priorities 6



SAB Self Assessment

The Safeguarding Adults Board holds an annual development session to review progress against the Care Act and the priorities from the previous year. The graphs below shows the results of the SAB's self-audit in 2015/16 and 2016/17.



At the March 2017 development session, the partners undertook a self-assessment of the work of the SAB. This graph shows the partners' analysis across a number of areas for 2016/17.

Comparison of the scores for 2015/16 and 2016/17 show that whilst the SAB has made progress in some areas, there are areas where the SAB partners believe that progress has slipped. This is particularly evident in relation to the learning from Safeguarding Adult Reviews. Board members scored the partners as amber overall. This relates to a concern that whilst learning is disseminated there is evidence that this is not being embedded in practice as similar themes are arising in subsequent reviews.

Making Safeguarding Personal remains amber. This has been identified throughout the year as an area for requiring further work. A working group was established to undertake some background research.

The self-assessment identified that compliance with the Mental Capacity Act remains low. This accords with findings from SARs undertaken this year. The Board will be working with partners to strengthen the confidence of practitioners in the application of the Mental Capacity Act in their practice. Staff supervision and reflective practice is being incorporated into the Multi Agency Case File Audit process led by the Independent Chair of the Board and supported by partner representatives.

Theme	What did we do?	Actions for the future
Information Sharing	Information sharing agreement and SAR Procedure which sets out information sharing requirements and commitments of partners.	Increase in information sharing across partners. Performance data information sharing processes need improvement.
Learning from SARs and other reviews	Learning events for SARs. Complex Case Panel in place. Development sessions to explore learning from Regulation 28 reports.	Strengthen learning from DHRs, SARs and national SARs. Measure the impact of learning from SARs.
Making Safeguarding Personal (MSP)	Audit tools and processes in place. Safeguarding Case File Multi Agency Audit used to identify examples of MSP. Complex Case Panel meetings to support practitioners to manage risk. Roll out of the risk management tool to front line staff.	MSP training programme to be developed. MSP learning to be incorporated into SAB Learning and Development programme. New IT system will make it easier to record MSP. SAB Audit Tool to be rolled out across the partners in 2017/18.

<p>Prevention from abuse and neglect</p>	<p>Care Act training in place. Adult Safeguarding Multi Agency Policies and Procedures adopted. iCare campaign information distributed. Training/resources available for hoarding and self-neglect cases. SAB web pages include resources for the community and professionals.</p>	<p>iCare campaign relaunch. Hoarding Policy to be agreed and launched. Disseminate information about the role of the Designated Adult Safeguarding Manager.</p>
<p>Staff supervision and reflective practice</p>	<p>Multi Agency Case File Audit and Complex Case Panel meetings to reflect on practice. Learning events for SARs and other reviews provide an opportunity for reflective practice.</p>	<p>The SAB requires further assurance that partners are providing supervision at all levels. Partners to review supervision process to ensure that they include safeguarding issues and MSP.</p>
<p>Mental Capacity Act (MCA) & undertaking assessments</p>	<p>SARs have identified that undertaking MCA assessments and recording of information is still an issue. The Safeguarding Case File Audit provides an opportunity to explore the application of MCA in practice and recording of information.</p>	<p>Training on undertaking MCA assessments and recording of information.</p>
<p>Transparency and openness to challenge</p>	<p>Care Act Multi Agency Policy and Procedures training undertaken. Regulation 28 report board session. Challenge to partners in respect of demonstrating Duty of Candour, openness and transparency. Quality assurance work with provider market and CQC. Implementation of the safeguarding audit tool enables practitioners to assess themselves. Independent chair and SAR reviewers meet with clients and families.</p>	<p>Continue to raise challenges to ensure openness and transparency to safeguard adults at risk.</p>
<p>Safeguarding training</p>	<p>Single agency and multi agency training plan in place. Learning events related to SARs and other themes. Safeguarding online training available to providers. Adult Safeguarding Level 2 Training packages being implemented at GP Protected Time Initiative events.</p>	<p>Further development of multi agency training plan. The training programme needs to reflect learning arising from local and national SARs and other reviews.</p>

Access to legal advice	The SAB has access to legal advice which has informed decision making at board level. All front line practitioners have access to legal advice to support decision making at a case management level.	The SAB will access independent legal advice where required.
Prevent strategy	All partner organisations have Prevent training in place.	Continue to ensure Prevent training is available to all partners.
Feedback informs policy	Feedback from learning events used to inform policy and practice. Team meetings, one to ones and reflective practice give practitioners opportunity to review and feedback.	Work more closely with Healthwatch to contribute to questionnaires and surveys.
Accessible safeguarding information available	Multi Agency Safeguarding Policies and Procedures adopted and on website. iCare campaign undertaken. Production of an 'easy read' reviews guidance leaflet.	Continue to improve SAB web pages to provide accessible information to the community and professionals. Relaunch iCare campaign.
Support with independent advocate	Advocacy services contract in place. Language Shop contract in place to support people to access advocacy services.	Quality assurance reports to the SAB in relation to advocacy services.
Safe recruitment processes in place	Partners and commissioned providers follow safer recruitment guidelines including references, DBS checks and audit these processes.	The SAB to seek assurance that safe recruitment systems and processes are in place.
Management of complaints	Sharing of the Local Government Ombudsman guidance of complaints about SABs. Partners and commissioned providers have complaints and whistle blowing procedures in place.	The SAB to seek assurance that partners comply with their complaints and whistleblowing policies.

SAB Achievements and Challenges

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SAB Achievements

The board and the committees have worked hard to establish effective partnership working and undertake work to improve safeguarding practice across Barking and Dagenham.

The Safeguarding Adult Review process has been tested and embedded with the commissioning of three SARs in 2016/17. Following the success of a hoarding training event that was the outcome of a single agency review, the board led further hoarding events, in partnership with the LSCB, recognising the safeguarding risk to children and other family members.

A Multi Agency Case File Audit is undertaken quarterly, led by the Independent Chair, to identify areas for improvement and also best practice that can be shared across the partnership.

As a result of single agency reviews, SARs and a Domestic Homicide Review, the Complex Case Panel has been set up to provide support to practitioners who are dealing with complex cases.

The board have undertaken a learning session around Regulation 28 reports and invited the Coroner and partners to share the learning that has been undertaken in relation to these.

There has also been partnership working around quality assurance reviews to improve standards in the care market.



SAB Challenges

In June 2016 the Safeguarding Adult Board discussed Dr Haq, a General Practitioner (GP) who had practiced at Abbey Medical Centre, in Barking between 2004 and 2014. In March 2016 he was found guilty of five counts of indecent assault while working as a GP in Hatfield in the 1970s and early 1980s. He was jailed in March 2016 for 18 months.

Dr Haq has been removed from the General Medical Register and has not worked as a doctor since 2014.

This was reported in the media in March 2016. The SAB asked NHS England (London), in line with the Duty of Candour, how former patients at Abbey Medical Centre would be informed of the offences so that they could raise any concerns regarding the care they had received from Dr Haq. NHS England (London) were reluctant to inform patients, believing that because the case had been reported in the national press, patients who had concerns would have raised these. The board and

independent chair rejected this rationale and sought a more robust response from NHS England (London). Ultimately, after 11 months, in February 2017, all patients who were registered with Dr Haq, were written to by NHS England (London) and the national contact centre was available for any patient who wished to report an incident or ask for further information or advice.

The SAB invited the Medical Director from NHS England (London) to a board meeting to allow for lessons learnt to be identified. These included:

- The paramountcy of safeguarding all patients in line with The Duty of Candour.
- The role of the Local Authority Designated Officer in providing advice to safeguard adults and children at risk of harm.
- Cultural issues which may impact on patients feeling able to share sensitive information.
- Ensuring learning is shared across the General Practitioner community.

In addition to this, the SAB has undertaken a review to strengthen the Safeguarding Adult Review process, as a result of partnership issues regarding the agreement of findings, recommendations and final sign off of SAR reports.

Safeguarding Adult Reviews 9

The Safeguarding Adult Review committee, under the Care Act, has responsibility for commissioning and leading on SARs and single agency reviews.



During 2016/17 the Safeguarding Adults Board commissioned three Safeguarding Adult Reviews. Independent reviewers were appointed to lead on these. The Safeguarding Adult Review Committee oversaw the reviews and presented the final report to the Safeguarding Adults Board for sign off and agreement for publication.

Safeguarding Adult Review 'Lawrence Beasley'

The Safeguarding Adult Review Panel commissioned this review using the 'Learning Together' methodology. Two reviewers from Social Care Institute of Excellence (SCIE) led the review along with a 'review' group, who oversaw who undertook the conversations and gathered further information. The 'case' group were made up of front line staff from partner agencies who were interviewed and provided further information to the review. The review group and case group were given the opportunity to come together to discuss the 'key practice episodes' and the findings.

Lawrence was a 63 year old man living in sheltered accommodation. He had a medical history of Type II Diabetes, paranoid schizophrenia and hyperthyroidism. He received insulin injections twice daily from the district nursing service although sometimes he was not compliant with this. On 9th March 2016, Lawrence was admitted to hospital with haemoptysis. On 17th March 2016 Lawrence was discharged from hospital. He was found deceased in his flat on 21st March 2016.

The key findings from this SAR were:

- Managing safe hospital discharge

- Mental Capacity Assessments, and
- Managing risk.

Safeguarding Adult Review 'Mary'

Mary was an elderly woman who lived on her own in Dagenham. During February 2016 several calls were made to the Police, regarding an intruder. These were unfounded. A merlin was raised and in early March a social care assessment was carried out. Mary was offered an extensive care plan but she was not keen to accept this. After some persuading Mary agreed to one visit per day (Monday to Friday only). On 9th June at around 5pm, Mary's neighbour called an ambulance as Mary was again complaining of shortness of breath. The ambulance took her to King Georges Hospital where she was seen in the emergency department, treated and identified as fit for discharge at around 9pm. Due to a shortage of available hospital transport Mary was not taken home until 5am on 10th June. The care agency attended to carry out the scheduled visit on the Friday morning, however the neighbour (who was unaware of Mary's return from hospital) told the carer she was still in hospital. He also voiced his anger at the carer about Mary's key being left in the door. He had taken in the key when it was discovered in the door rather than putting it back in the key safe. Mary was not due to have another carer visit over the weekend. The neighbour saw Mary on the Friday afternoon. The care agency did not attend on the Monday 13th June. On 14th June the neighbour called the police as he had not seen Mary for a few days. The police called for an ambulance and the ambulance crew found Mary deceased in her home.

The key findings from this SAR were similar to the previous one in terms of:

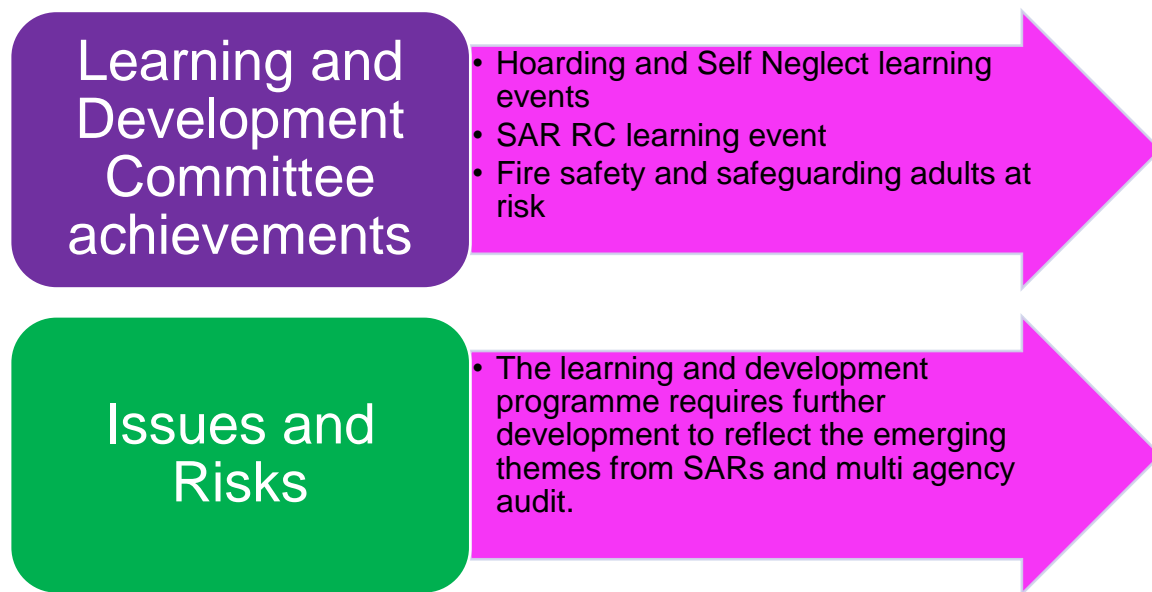
- Managing safe transfer home from the Emergency Department
- Effective communication and information sharing
- Mental Capacity Assessments, and
- Managing risk.

The third SAR that was commissioned in 2016/17 is still ongoing.

The full Safeguarding Adult Review reports and the executive summaries can be found at this link

<http://careandsupport.lbbd.gov.uk/kb5/barkingdagenham/asch/advice.page?id=cGthvG2UuNE>

The Learning and Development committee has responsibility for developing and commissioning the training plan for the SAB. The training plan is based on statutory requirements in line Care Act, recommendations arising from SARs and other reviews and emerging themes from multi agency audits and the Complex Case Panel.



The Safeguarding Adults Board, colleagues from partner organisations and the Safeguarding Children Board have led and taken part in a number of learning and development opportunities over the last year.

Safeguarding Adult Review Learning

A learning event was held on the SAR RC case that was published at the end of 2015/16. The independent reviewer presented the case and talked through the findings. The learning event focussed on:

- Issues around people with learning disabilities and dysphagia
- Managing risks in a care setting
- Joint working
- The Mental Capacity Act
- What has been implemented to improve processes and practices in response to the case.

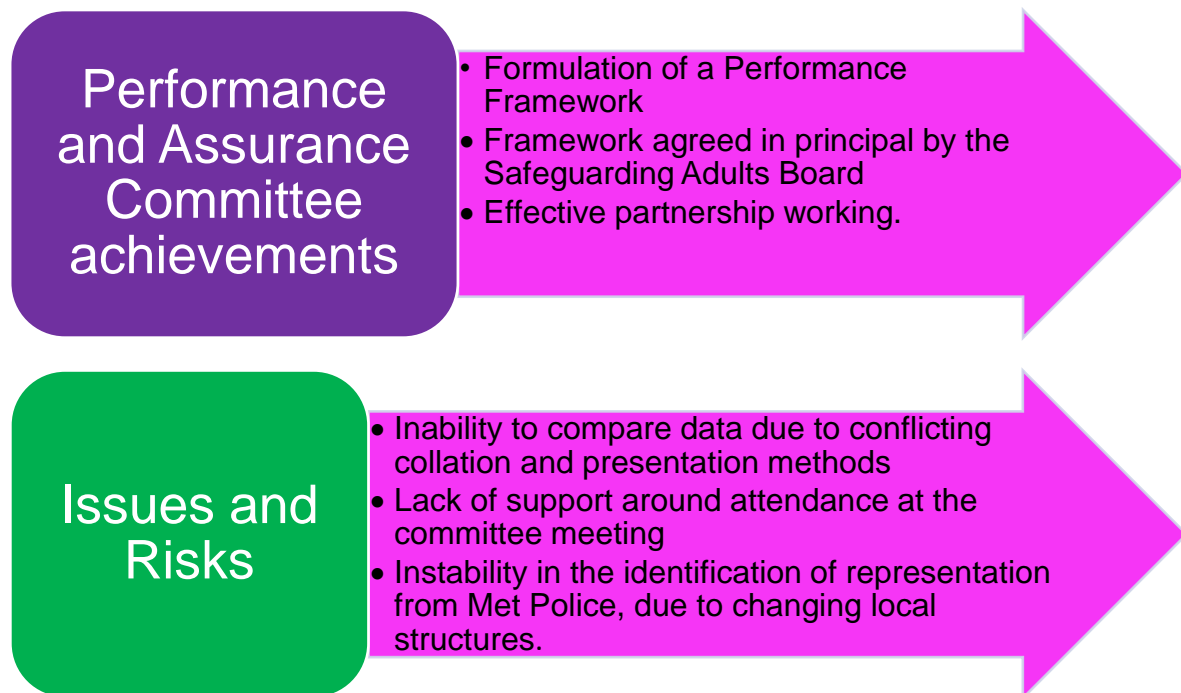
Hoarding

Following a management review around hoarding that took place in 2015/16 and subsequent feedback which stated that further events would be useful, a hoarding learning event took place. Around 40 SAB partners and front line staff attended. There were presentations from a psychologist, the Fire Service and Environmental Services. Attendees took part in workshops and used the hoarding risk and audit checklists and looked at case studies to increase their knowledge and understanding of the issues facing hoarders. Positive feedback was received and a further event has taken place aimed specifically at commissioned providers. The SAB have developed a hoarding policy that includes hoarding assessment tools to support frontline practice.



Performance and Assurance 11

The Performance and Assurance committee has responsibility for developing the performance framework to enable the SAB to understand safeguarding performance across the partnership. This informs future quality assurance activity including audit and deep dives.



Regulation 28

The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a 'preventing future deaths report'. The report is sent to the people or organisations who are in a position to take action to reduce the risk. They then must reply within 56 days to say what action they plan to take.

A number of these reports have been sent from the Coroner to our partners. The board invited the Coroner to a SAB meeting along with the partners, to give a verbal update on what measures have been put in place to ensure that similar issues do not occur in the future and how they intend to manage the risks. The SAB is interested in the safeguarding and learning from these reports and how it can facilitate learning across partners and organisations.

The board committed to undertaking learning from Regulation 28 report in the coming year.

Complex Case Panel

A new Complex Case Panel has been set up. The purpose of this meeting is to share information on cases presenting with the highest risk and complexity. The panel is made up of representatives of the local authority, community health services, the environmental and housing services, the police, the fire brigade and other professionals, as and when required. The panel will consider complex cases that may require multi agency communication and approach to addressing risk. After sharing all relevant information about the adult at risk, the panel members will discuss options and support to address the issues. The main focus of the Complex Case Panel is to review the risk to the adult and consider other persons affected and the wider community. The panel will support professionals in decision making for ongoing case management.

Multi Agency Safeguarding Case File Audit

The purpose of the Multi Agency Safeguarding Case File Audit meeting is to share, discuss and audit multi agency safeguarding practice. The aim is to gain greater understanding of practice, issues and challenges at the front line in order to encourage multi agency thinking and share the outcomes across the partnership. It also an opportunity for the SAB independent chair, to find out more about safeguarding processes in the borough and assess whether there is anything that the SAB partnership can do to improve or review systems and processes to support practitioners. The good practice and learning is shared more widely. Key themes have included Mental Capacity Assessment, Making Safeguarding Personal and management supervision.

Safeguarding Quality Assurance Audit

A quality assurance audit process has been developed and implemented for safeguarding enquiries. The purpose is to assure the board of the compliance to the Care Act and the Multi Agency Adult Safeguarding Policy and Procedures across all partners. The results of the audit are being fed back to the board and managers to support them to take forward any learning with their staff. As a result, this has identified that compliance with the London Multi Agency Safeguarding Policy and Procedure was variable across partners. This has led to training with staff teams and providers and the development of a new safeguarding concern form to ensure compliance with the Care Act, as well as new tools for enquiry officers and Safeguarding Adult Managers.

Barking Havering and Redbridge Unitary Trust (BHRUT) CQC Inspection

In 2013 the Trust was inspected by the Care Quality Commission (CQC) and due to concerns, was placed in special measures. The CQC returned to inspect the Trust in March 2015. Overall, the CQC found that improvements had been made, however it was evident that more needed to be done to ensure that the Trust could deliver safe, quality care across all core services.

The CQC carried out an unannounced inspection in September and October 2016, to review the progress of the improvements that had been implemented, to apply ratings, and also to make recommendations on the status of special measures.

The CQC inspected four of the core acute services including urgent and emergency care, medical care (including older people's care), services for children and young people, and outpatients and diagnostic services, at both the Queen's Hospital and King George Hospital sites.

To understand patients' experiences of care, the CQC asked the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The Trust has now come out of special measures.

The key safeguarding findings were:

- In line with statutory guidance the Trust had named nurses, named doctors, and safeguarding teams for child protection and safeguarding adults at risk.
- The safeguarding adult and children policies were available on the Trust intranet and were up to date. Safeguarding was part of the Trust's annual mandatory training.
- Staff we spoke with were aware of their responsibilities in relation to safeguarding adults and children. Staff were able to give examples of what would constitute a safeguarding concern and told us they would seek advice from senior staff members and the trust safeguarding team if they had any concerns.

- All staff we spoke with knew the safeguarding team and could identify where to find the contact details if required.
- There was a monthly safeguarding and learning disability operations group, where any issues around safeguarding or staff awareness of processes were shared.
- Staff had a good understanding of female genital mutilation (FGM) and knew they could access the safeguarding lead for any support.
- In the Emergency Department at the King George Hospital completion of safeguarding training by doctors was low. Compliance with safeguarding adults level 2 was 73% and safeguarding children level 3 was 60%.

Areas of safeguarding good practice identified were:

- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood. This had been positively evaluated and received a high standard of feedback from parents and patients.
- Child to adult transition services were comprehensive and conducted with the full involvement of the patient and their parents. This included individualised stages of empowering the person to gradually increase their independence, the opportunity to spend time with paediatric and adult nurses together and facilities for parents to spend the night in adult wards when the young person first transitioned.

North East London Foundation Trust (NELFT) CQC Inspection

The inspection took place in April 2016. Overall NELFT were rated as 'requires improvement'. The Trust had a number 'must do' actions that it undertook to improve care. As with the BHRUT inspection, the same five questions were asked of every service and provider.

The key safeguarding findings were:

- In the community health services there were major staffing shortages and recruitment challenges across all staff groups and localities. There was a high use of agency and bank staff across these services which impacted on the services provided.
- Within the community health services for adults there was a lot of variation in referral to treatment times for accessing specialist nursing services. The trust did

not have a system in place for monitoring referral times to treatment in district nursing.

- In acute inpatient settings risk assessments, risk formulations and care plans were not always being updated and reviewed.
- Patients' personal preferences were not always reflected in care plans. Not all patients had been given a copy of their care plan.
- Access to psychological therapies for people with mental health problems was not consistently provided across the trust.

Areas of safeguarding good practice identified were:

- The community treatment team worked closely with local acute hospitals to reduce emergency admissions to hospitals for patients, who were treated in their own homes. The service has been highly commended and has won a national patient safety award in partnership with the London Ambulance Service.
- The trust had a positive approach to equality and diversity amongst its workforce. Their work on this agenda led to the trust winning the inclusive networks award. The trust had been nominated for the Diverse Company of the Year award at the National Diversity Awards 2016 and had been cited as one of the top ten global black and minority ethnic networks by The Economist in February 2016.
- The trust has good overall systems and processes for managing safeguarding children and adults at risk. The trust was represented at all local authority safeguarding boards and contributes to sub groups.

Following the CQC inspection a Quality Summit was held where an action plan to address areas of improvement was agreed with partner agencies which is being taken forward.

Partnership Priorities for 2017/18

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The board considered the work of the SAB in light of the changing context of health and social care and of partner organisations, emerging risks and financial pressures. The board recognises the need to have oversight of safeguarding practice to ensure that quality of care is not compromised. The SAB has a role to play in supporting the workforce across the partnership, ensuring that they have the skills and competencies to fulfill their roles.

“Some thoughts on future challenges...”

Barking & Dagenham
Safeguarding Adults Board
Development Session
22 March 2017

Mark Topp
Communications Director, Adults' Care & Support



Safeguarding Adult Board Priorities for 2017/18

The Safeguarding Adult Board priorities for 2017/18 are set out below. These are incorporated into the SAB's strategic plan and committee work plans.



Healthwatch, Barking and Dagenham have worked in partnership with the Adult Safeguarding Board throughout the year and are a member of the Performance and Assurance committee.



The particular role of Healthwatch is to be the voice of patients and service users of Health and Social Care. Healthwatch fully support the board's priorities around Making Safeguarding Personal and believes that people who are making the difficult journey through the safeguarding process should be empowered to make decisions and achieve outcomes that are important to them. Healthwatch is committed to ensuring that service users' views are central to improvements made to the safeguarding process, and are committed to working in partnership with the Board to ensure that this continues to happen.

Further Information about Safeguarding 15

For further information about safeguarding and information about the Safeguarding Adults Board please use the following link

<https://www.lbbd.gov.uk/residents/health-and-social-care/adults-care-and-support/safeguarding-adults/safeguarding-adults-overview/>

To report a safeguarding concern:

Adult Social Care Intake and Access Team

020 8227 2915

intaketeam@lbbd.gov.uk

Out of Hours Emergency Social Work Duty Team

020 8594 8356

intaketeam@lbbd.gov.uk

In an emergency:

Call 999 and ask for the Police

Call 101 if you are worried but it is not an emergency.