## Safeguarding Adults in Hammersmith and Fulham

# Safeguarding Adults Committee
# Annual Report 2009/10

## EXECUTIVE SUMMARY

The Safeguarding Adults Committee provided effective leadership for the borough's safeguarding policy and practice throughout the year. All partners were engaged and membership grew to include, amongst others, representation from the LINk, Better Government and carers.

In 2009/10, Hammersmith and Fulham received 457 safeguarding alerts, 32% more than the 346 received in 2008/09. This is a lower rate of increase than the 46% increase in 2008/09 compared to 2007/08. Benchmark data for 2008/09 published in May indicates that Hammersmith and Fulham received a higher rate of safeguarding alerts compared to the average London borough but was not an outlier.

There was a marked increase in 2009/10 in the number of alerts recorded as being from vulnerable adults themselves. In 2009/10, 70 or 15% of alerts were raised by the vulnerable adult; in 2008/09, 23 or 7% and in 2007/08, 3 or 2%. This may be a function of an increased awareness of abuse and how to report it amongst vulnerable adults, more intensive efforts to promote basic awareness of abuse and the safeguarding process amongst partners and improved recording practice by adult social care and integrated teams.

For the last three years, the two single largest categories of alleged abuse have been financial and physical; this year, financial abuse has been the largest. In the majority of alerts, the alleged abuse was stated to have taken place in the vulnerable adult's own home. In the majority of alerts, the alleged perpetrator was a family member or relative, friend or neighbour. Given these conditions, the increase in vulnerable adults' self referrals is especially important.

A greater number of alerts were closed at alert stage and a greater number of alerts were also progressed to investigation in 2009/10 than in 2008/09. Despite the increase in the number of alerts and the increase in those progressed to investigation, virtually the same number of vulnerable adults were found to have been abused; 86 as of March 31st 2010 and 89 as of March 31st 2009.

Alerts were especially likely to be substantiated or partially substantiated for vulnerable adults in receipt of services from the drugs and alcohol team and, to a lesser degree, older people. In the majority of substantiated or partially substantiated cases, the perpetrator was a partner, other family member, family carer, friend or neighbour, the abuse was physical or financial and took place in the vulnerable adult's own home. These findings will inform the proposed Safeguarding Adults Strategy.

Learning disabilities had an especially high number of repeat alerts; of the 79 alerts for learning disabilities, 32 related to the same 14 service users. This may have been a function of the user group, particularly given that learning disabilities alerts are no more likely than mental health or physical disabilities alerts to be substantiated or partially substantiated, but this will be further analysed in 2010/11.

Quality assurance audits demonstrated a continued improvement on the 2008 baseline audit; in 2010 55% of cases were 'adequate' of which 31% were 'good' or 'excellent' compared to 2008 when only 8% were 'adequate' and none were better. The 2009 audit outcome of 72% 'adequate' and above and 28% 'poor' was likely to have been the result

of intense scrutiny at the time. In 2008 partners agreed a model whereby adult social care lead and manage all investigations and investigations were undertaken by specialist professionals from partner agencies. Evidence suggests that this model is still the most effective way to investigate abuse. Work is in progress to ensure that there are sufficient appropriately trained and accredited investigators in each agency.

The sustained improvement in safeguarding practice combined with the unchanged number of alerts where abuse was substantiated or partly substantiated suggests that a more refined process whereby alerts could be closed after safeguarding strategy as well as at alert stage and at review stage could be usefully implemented, as is accepted practice in some London boroughs. The Safeguarding Adults Committee agreed this change in June 2010.

To date, intensive learning and development interventions have been the main approach to improving practice. In 2010/11, adult social care will be seeking to make a further, sustainable step change in safeguarding practice. This will include a change to the skills mix so that care management is no longer a social work function thereby freeing social workers to concentrate on professional practice with safeguarding as a core task; a change to the team structure such that the supervisor:social worker ratio is far smaller and better able to focus on professional practice and the invoking of formal performance management procedures where appropriate. It is intended that these actions will support the borough in achieving its target of 100% of safeguarding cases managed at an ‘adequate’ and above level and 60% managed at a ‘performing well’ and above level.

# SECTION ONE: SAFEGUARDING ADULTS COMMITTEE

## 1.1 Safeguarding Adults Committee and Sub Groups

The Safeguarding Adults Committee provided effective leadership for the borough's safeguarding policy and practice throughout the year. The committee is regularly attended by all partners. Attendance has grown; Adult Education, Central North West London Mental Health Trust, the Senior Joint Carer's Commissioner and the Carers' Centre are now represented and the Co Chair of the LINK and the Chair of the Better Government Consultative Committee now attend to represent the views of vulnerable adults and the public.

The committee's sub groups were reviewed. The four sub groups are now; Quality Assurance, Training, Care Homes and Home Care and Information and Involvement. The work of the sub groups has progressed through the year. The Quality Assurance Subgroup was established in April 2009 and brings the statutory partners together to monitor practice and performance across agencies. The Quality Assurance Sub Group will review quality assurance mechanisms across all partners; it has agreed to use the Department of Health's 'Clinical Governance and Adult Safeguarding' guidelines as a standard framework for the four health and social care statutory agencies which other partner agencies will have the option of adopting.

The Training Subgroup revised its training programme and, as well as the ongoing basic awareness and investigators and chairs training, commissioned training pertaining to safeguarding regarding financial abuse and domestic violence and coaching and mentoring team based sessions.

The Involvement and Information Subgroup, incorporating the Public Information Subgroup, was established in April 2009 and agreed communication and involvement plans focused on further increasing public awareness regarding abuse and safeguarding procedures and ensuring that people's experiences of being safeguarded informed practice improvements. In response to what people said made them feel safe, adult social care introduced a fast track system for assistive technology where it formed part of a protection plan.

The Care Homes and Home Care Subgroup achieved excellent results; the incidence of abuse in care homes in the borough has continued to decrease proportionately from 2007/8 levels. This subgroup led on driving up the quality of care home provision in care home and in domiciliary care settings. The subgroup was chaired by the council's Deputy Head of Procurement, Quality, Commissioning and Procurement and brought together commissioning and provider agencies to identify and address areas of concern. A database tracked safeguarding concerns on all care homes used by the council and a protocol for the suspension of placements is being developed. Procurement officers attended all safeguarding meetings relating to investigations in care homes both in the borough and in other local authorities All safeguarding incidents that occur in regulated contracted services were reported to the Procurement Team and their outcomes tracked.

The committee was briefed on the implementation of the Independent Safeguarding Authority and each partner has considered the impact. In adult social care and integrated teams, managers have been briefed on their responsibilities in relation to

referrals to the ISA. The committee was also briefed on personalisation. The committee agreed a Serious Incident Review Policy.

The committee continued to implement those actions set out in the action plan for 2009/10. Actions implemented included reviewing the quality assurance framework for safeguarding, holding a series of workshops to disseminate the findings of safeguarding audits, establishing ongoing means of understanding people's experiences of being safeguarded and additional actions devised by safeguarding chairs and investigators regarding services for each particular service user group. Outstanding actions will be reviewed and folded into the Safeguarding Adults Strategy where appropriate.

### 1.2 Safeguarding Adults Strategy

The Safeguarding Adults Committee agreed two strategic intentions for the next three years; preventing abuse of vulnerable adults from occurring and protecting vulnerable adults from abuse where abuse has already occurred and/or there is a risk of abuse occurring. This will be the first time that the committee has focused on preventative as well as protective action.

The committee agreed ten priorities under these strategic intentions. These are set out below:

Preventing Abuse
1 To campaign against abuse
2 To help people to protect themselves
3 To protect carers
4 To prevent the abuse of people whose care we provide or arrange
5 To prevent the abuse of people who arrange their own care

Protecting From Abuse
6 To recognise and report abuse
7 To improve safeguarding practice
8 To assure the quality of safeguarding practice
9 To learn from the experience of vulnerable adults
10 To learn from our information on abuse

Proposed actions pertaining to each priority have been identified. The Safeguarding Adults Strategy will be subject to consultation in the summer of 2010.

### 1.3 Safeguarding Partners

**Adult Social Care and Integrated Teams** - In adult social care and integrated teams a robust programme of quarterly audits, a weekly safeguarding panel, team based practice support and mentoring have been provided. A rolling investigators and managers/chairs training programme has ensured that all relevant staff are trained. In order to support good practice, refresher training was commissioned for both investigators and managers. The assessment of adult social care and integrated teams' chairs and investigators practice is now embedded in the annual appraisal process. Staff must not only have undertaken training in the last year but achieved a standard of 'good' or above in two recent investigations. Accreditation will be given with the agreement of the Quality Assurance Manager, Safeguarding.

**Imperial College Healthcare Trust Board** (ICHT) - In 2009, ICHT set up a Safeguarding Adults Board to provide leadership and strategy in the Trust. The board is chaired by the executive lead in safeguarding and its membership includes operational leads for both the Charing Cross/Hammersmith Hospitals and the St Mary's sites, clinical governance leads, the seven Clinical Practice Group managers and Safeguarding Adult Coordinators from Hammersmith and Fulham and Westminster councils. The board ensures that data systems work effectively and accurately to reflect safeguarding activity within the Trust and develops close operational relationships with its partner agencies. The Committee meets quarterly; additional monthly meetings are planned to share data and discuss operational issues. The Trust provides a range of training in safeguarding adults; as well as induction training, there is basic awareness, investigators and 'expert' training. The content of the investigators training will be discussed further to ensure that issues specific to safeguarding are addressed. In ICHT, several managers have undertaken the 13 investigations in 2009/10. One member of staff attended the borough's investigators training in 2009/10 and there are no accredited investigators. 4 investigations were substantiated or partially substantiated, and 3 were ongoing. ICHT raised 14 alerts in 2009/10.

**NHS Hammersmith and Fulham** - NHS Hammersmith and Fulham's lead officer for safeguarding is the Associate Director Quality and Safety. The lead officer has presented the draft safeguarding strategy to the Clinical Governance Board. Progress has been made in ensuring that safeguarding is now included in contracts with providers including general practitioners. The Associate Director, Quality and Safety will identify the most appropriate staff to attend the Safeguarding Adults Committee's four sub groups. No staff have attended investigators training in 2009/10. No investigations were undertaken in 2008/09.

**Central London Community Health (CLCH)** – CLCH's lead officer for safeguarding is the Director of Services. The operational lead, a clinical nurse manager, represents CLCH from Hammersmith and Fulham and attends both the Safeguarding Adults Committee and the Training and Quality Assurance Sub Groups. In CLCH, 3 managers have undertaken investigators training but not in the last year and no one is accredited. 2 investigations have been undertaken by the clinical nurse manager in 2009/10.

Together NHS H&F and CLCH raised 26 alerts.

**West London Mental Health Trust (WLMHT)** - WLMHT holds a monthly Clinical Improvement Group to track current safeguarding investigations. At the half year, the Trust had 55 trained investigators.

**Central North West London Mental Health Trust (CNWLMHT)** - CNWLMHT has its own Safeguarding Committee to which the Quality Assurance Manager, Safeguarding is invited. A manager in the Drug and Alcohol service in Hammersmith and Fulham has recently attended the Safeguarding Adults Committee and the training needs of staff are now being addressed. No staff are trained in investigation and no one is accredited.

**Police**

All alerts must be reported to the Police and most are now reported via the public protection desk from where they are directed to the most appropriate department. The response is then left with the police as to whether they take further action. The police

participate in safeguarding meetings where appropriate. 17 alerts were raised by the police.

**Voluntary Sector**
The number of alerts from the voluntary sector has risen from 4 in 2008/09 to 12 in 2009/10. This reflects the increased awareness and involvement of the voluntary sector in safeguarding adults.

# SECTION TWO: PROFILE OF PEOPLE SAFEGUARDED

## 2.1 SAFEGUARDED POPULATION IN LONDON

The Care Quality Commission (CQC) publish safeguarding data for London. The 2008/09 data, published in May 2010, sets out rates of alerts for older people, people with physical disabilities, people with mental health needs, people with learning disabilities, people with needs arising from drug and alcohol misuse and informal carers.

In 2008/09, based on the incidence of safeguarding alerts across all thirty three London boroughs including the City of London, average London alert rates can be determined for each of the user groups listed above.

For the average London borough 65+ population, in 2008/09 a safeguarding alert would be made for 0.7% of that population. This equates to 7 safeguarding alerts per thousand 65+ population per year. On the basis of CQC data published in 2009 for 2007/08, the average London borough received alerts for 0.5% of its 65+ population or 5 alerts per thousand 65+ population per year. The rate of alerts per year for this population has increased by 40%.

For the average London borough under 65 population, in 2008/09 a safeguarding alert would be made for 0.091% of that population. This equates to 0.91 safeguarding alerts per thousand under 65 population per year. On the basis of CQC data published in 2009 for 2007/08, the average London borough received alerts for 0.065% of its under 65 population or 0.65 safeguarding alerts per thousand under 65 population per year. The rate of alerts per year for this population has also increased by 40%.

These figures do not take into account informal carers as they are not counted separately in Hammersmith and Fulham.

## 2.2 POPULATION IN HAMMERSMITH AND FULHAM

The Mid Year Estimate (MYE) 2008 indicates that the 18+ population in Hammersmith and Fulham is 141,140 (MYE, Office of National Statistics 2008).

Of the total 18+ population, 123,637 (87.6%) were under 65 and 17,503 (12.4%) were above 65 (MYE, Office of National Statistics 2008).

Of the total 18+ population, 51% are male and 49% are female (MYE, Office of National Statistics 2008). This varies dependent on age; of the 65+ population 57% are female and 43% are male; of the under 65 population 49% are female and 51% are male.

Great London Authority (GLA) round projections 2008 are used to estimate the population's ethnic profile although the total population as per the GLA projections (143,823) differs slightly from the total population according to the MYE (141,140). Of the total population according to the GLA round projections 2008, 79% are white and 21% are from black and ethnic minority groups. This varies slightly dependent on age; of the 65+ population, 80.8% are white and 19.2% are from black and ethnic minority groups; of the under 65 population, 79.3% are white and 20.7% are from black and ethnic minority groups. The largest ethnic minority groups are Black Caribbean and Black African.

## 2.3 VULNERABLE ADULTS POPULATION IN HAMMERSMITH AND FULHAM

'No Secrets' defines a vulnerable adult as a person aged eighteen or over who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or, unable to protect him or herself against significant harm or exploitation. Binding guidance as to who is eligible for community care services is set out in the Fair Access to Care Services Criteria (DoH 2003). The person experiencing harm or exploitation should meet the 'low' threshold for adult social care in which case an allegation of abuse will escalate them to 'substantial' or 'critical'. People experiencing abuse who do not meet the 'low' threshold should use relevant complaints procedures or contact the police.

There is no established pool to which alerts may be compared. We have chosen the comparator pool to be those in receipt of community care services because this is the required CQC PAF return and because it is the most concrete pool upon which we can reply.

There are approximately 3800 people using adult social care services at any one time who might be vulnerable according to the 'No Secrets' definition. In 2009/10 approximately 61% of these were older people; 18% were people with a physical disability; 14% were people with mental health needs; 6% were people with learning disabilities and 2% were people with risk associated with drug and alcohol use. The figures for the integrated teams (mental health and learning disabilities) do not include those with health care needs, all of whom might also meet the definition of a vulnerable adult. If these figures were included it might affect the proportionality of the user group make up of safeguarding alerts.

The majority of people using adult social care services are women (approximately 63% are women and 37% are men at any one time).

At any one time, approximately 26% of people using adult social care services are people from black and minority ethnic groups.

## 2.4 SAFEGUARDED POPULATION IN HAMMERSMITH AND FULHAM

### 2.4.1 Safeguarding alerts

**Total safeguarding alerts**

**There was a 32% increase in alerts in 2009/10 compared to 2008/09. This is lower than the rate of increase in the previous 3 years.**

In 2009/10 there were a total of 457 safeguarding alerts compared to 346 alerts in 2008/09. This was a 32% increase. In 2008/09 there had been a 46% increase in the number of safeguarding alerts since 2007/08. One or two London authorities saw a decrease in the number of alerts they received in 2009/10 compared to 2008/09 (Kensington and Chelsea and Tower Hamlets, for example). On the basis of the rate of alerts received by two of these boroughs, Hammersmith and Fulham might have expected to receive 228 alerts for older people. On average there were 38 alerts per month in 2009/10, 29 alerts per month in 2008/09 and 20 in 2008/07. There was no obvious seasonality effect.

**Rates of total safeguarding alerts compared to average London rates**

**Hammersmith and Fulham received 9.9 alerts per year per 1000 people over 65 in 2008/09, compared to the 7 alerts received by the average London borough in the same year. Hammersmith and Fulham received 1.39 alerts per year per 1000 people under 65 in 2008/09, compared to the 0.91 alerts received by the average London borough in the same year. Although higher than average, Hammersmith and Fulham were not unusual in the rate of alerts for either age group.**

The CQC data used for comparative purposes uses the term ‘referrals’ instead of ‘alerts’. The term ‘alerts’ is used throughout this report.

There was a considerable range of rate of safeguarding alerts for the 65+ population across London. The number of safeguarding alerts for the 65+ population in London for 2008/09 ranged from 2 per 1000 (City of London) to 13.9 per 1000 (Tower Hamlets) per year. In 2008/09, the average London borough received 7 safeguarding alerts per 1000 65+ population per year and, on this basis, Hammersmith and Fulham would expect a total of 123 safeguarding alerts per year for 65+. In 2008/09, Hammersmith and Fulham received a total of 173 alerts for 65+ (9.9 alerts per 1000 over 65 population). This is higher than would be expected on the basis of the average London borough but boroughs with higher rates of safeguarding alerts in 2008/09 for the 65+ population such as Tower Hamlets (13.9 alerts per 1000 65+ population) and Kensington and Chelsea (13.7 alerts per 1000 65+ population) would have exceeded the average by more. In 2009/10, Hammersmith and Fulham received a total of 206 safeguarding alerts for the 65+ population or 11.77 safeguarding alerts per 1000 65+ population (compared to 9.9 safeguarding alerts per 1000 65+ population in 2008/09). This cannot be compared with the London average figures because they pertain to different years.

There was a considerable range of rate of safeguarding alerts for the under 65 population across London. The number of safeguarding alerts for the under 65 population in London for 2008/09 ranged from 0.16 (City of London) to 1.56 (Kensington and Chelsea) per 1000 per year. In 2008/09, the average London borough received 0.91 safeguarding alerts per 1000 under 65 population per year and, on this basis, Hammersmith and Fulham would expect a total of 113 per year for under 65s. In 2008/09, Hammersmith and Fulham received a total of 173 alerts for the under 65 population (1.39 alerts per 1000 under 65 population). This is more than would be expected on the basis of the average London borough, but again boroughs with higher rates of safeguarding alerts in 2008/09 for the under 65 population such as Kensington

and Chelsea (1.56) and Camden (1.53) would have exceeded the average by more. In 2009/10, Hammersmith and Fulham received a total of 251 safeguarding alerts for the under 65 population or 2 alerts per 1000 under 65 population (compared to 1.39 safeguarding alerts per 1000 under 65 population in 2008/09). This cannot be compared with the London average figures because they pertain to different years.

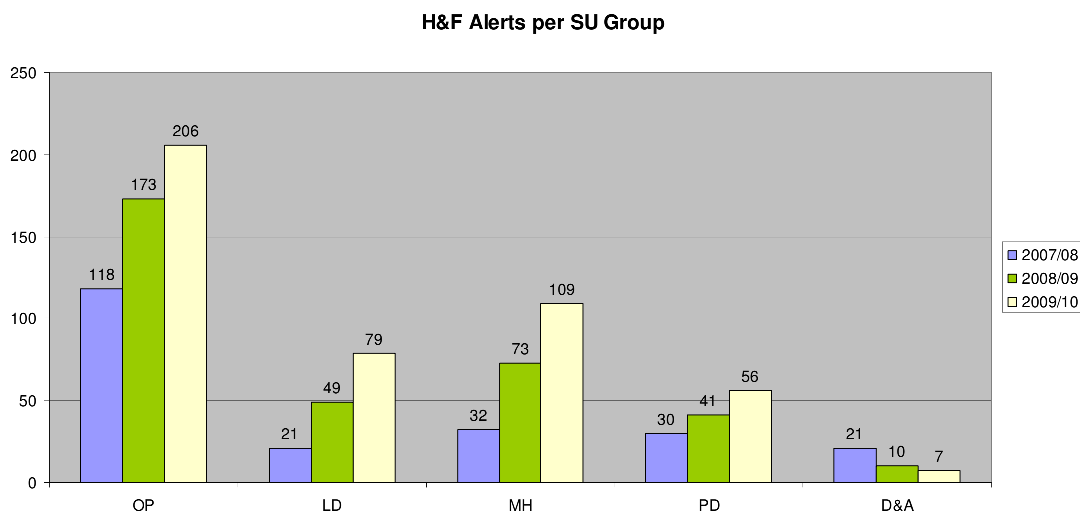
**Rates of alerts by user group**

**The greatest number of alerts relate to older people; learning disabilities and mental health are both over represented in terms of alerts compared to the adult social care service user profile.**

In Hammersmith and Fulham in 2009/10 the break down of alerts by service user group was: 206 or 45% older people, 79 or 17% learning disabilities; 56 or 12% physical disabilities,109 or 24% mental health; 7 or 2% drugs and alcohol and carers is not recorded separately.

This is compared to 2008/9 when 173 or 50% in Hammersmith and Fulham were for older people, 41 or 12% were people with a physical disability, 73 or 21% were people with mental health needs, 49 or 14% were people with learning disabilities and 10 or 3% were people with risks associated with drug and alcohol use.

In 2007/08, 118 (53%) of safeguarding alerts were older people; 30 (14%) were people with a physical disability; 32 (14%) were people with mental health needs; 21 (9%) were people with learning disabilities and 21 (9%) were people with risks associated with drug and alcohol use.

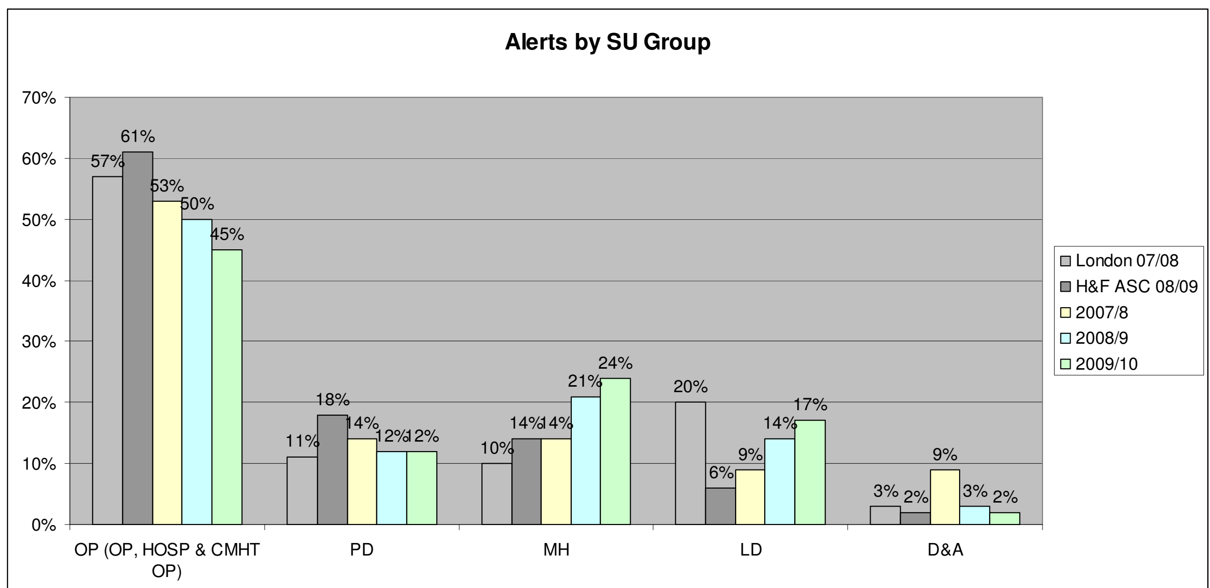



The proportions of safeguarding alerts in 2009/10 did not correlate with the proportions of adult social care service users. In 2009/10 alerts for people with mental health needs and learning disabilities were both over represented in comparison with the adult social care service user profile. This was also the case for 2008/09. This may be because these user groups have particularly high levels of vulnerability associated with capacity and drug and alcohol issues but this may also be a reflection of the concerted efforts to promote safeguarding in integrated teams.

The proportion of older people is lower than the proportion of older people in adult social care but, although decreasing proportionately because of the proportionate increase in alerts for mental health and learning disabilities, the actual number of alerts for older people increased in 2009/10 from 173 to 206.

Alerts for people with risks associated with drugs and alcohol have dropped by two thirds over three years although the proportion of alerts in the drug and alcohol service equates with the proportion of community care service users and the London benchmark. It may be that as drug and alcohol use is a feature of mental illness, these alerts are now being dealt with by mental health services.

The adult social care profile does not include people whose health care needs are met by the integrated teams. If these figures were included the profile of alerts by user group might be affected, particularly in relation to mental health and learning disabilities.

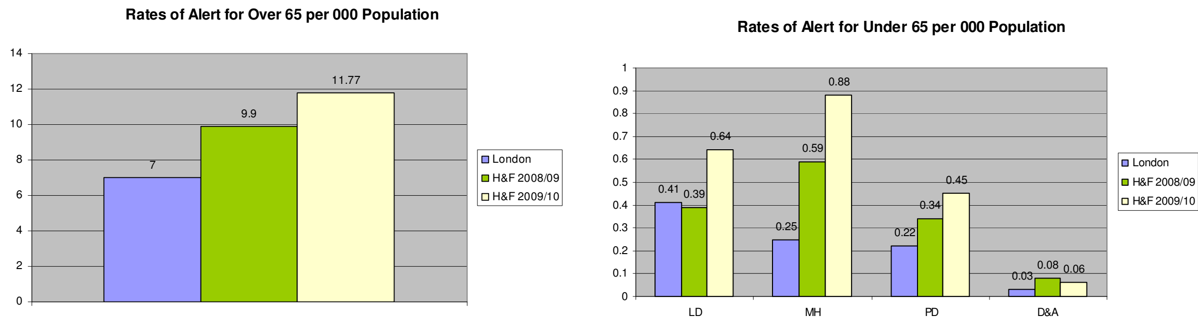



**Rates of alerts by user group compared to average London rates per user group – The 2008/09 Hammersmith and Fulham rates of alert per service user group per 1000 people per year are higher than or equal to the average 2008/09 London rates of alert for all groups.**

**Rates of Alert per 000 Population**

| | OP | LD | MH | PD | D&A | |
|---|---|---|---|---|---|---|
| **London** | 7 | 0.41 | 0.25 | 0.22 | 0.03 | 7.91 |
| **H&F 2008/09** | 9.9 | 0.39 | 0.59 | 0.34 | 0.08 | 11.3 |
| **H&F 2009/10** | 11.77 | 0.64 | 0.88 | 0.45 | 0.06 | 13.8 |

For the under 65 population, London average rates of alert per 1000 population are known for each service user group for 2008/09 and can be compared to Hammersmith and Fulham rates. A comparison can only be made between rates of alert per 1000 population for London and Hammersmith and Fulham 2008/09, as these pertain to the same year. The rate of alerts for Hammersmith and Fulham for 2009/10 is shown but this is not an accurate comparison because the London average rate of alert per 1000 population will probably have increased in 2009/10.




In 2008/09, the rate of alert per 000 population exceeded or was equal to the London average rate of alert in all service user groups.

**Source of safeguarding alerts - There was a 32% increase in alerts in 2008/09 compared to 2007/08.**

In 2009/10, there was a marked increase in proportion and actual number of alerts from vulnerable adults themselves. In 2009/10, 70 or 15% of alerts were raised by the vulnerable adult; in 2008/09, 23 or 7% and in 2007/08, 3 or 2%. This may reflect an increased awareness of abuse and how to report it amongst vulnerable adults as well as improved recording practice by adult social care and integrated teams.

In 2009/10 NHS, police, housing, probation and the Care Quality Commission raised 133 alerts, 29% of total alerts. Of these, 58 were from the NHS acute and primary health providers and the London Ambulance Service and 75 were from housing, police probation and the Care Quality Commission.

In 2008/09, NHS, police, housing, probation and the Care Quality Commission raised 126 alerts, 36% of total alerts. Of these, 33 were from the NHS acute and primary health providers and the London Ambulance Service, 29 were from health workers in integrated teams and 64 were from housing, police probation and the Care Quality Commission.

The number of alerts from NHS, police, housing, probation and the Care Quality Commission has decreased proportionately and increased only by 7 alerts.

The second largest group of alerts were raised by supporting people providers (11%) and care homes (9%), which combined make 20%. At 18% in 2008/09 and 20% in 2007/08 this was broadly unchanged year on year proportionately but actual numbers increased.

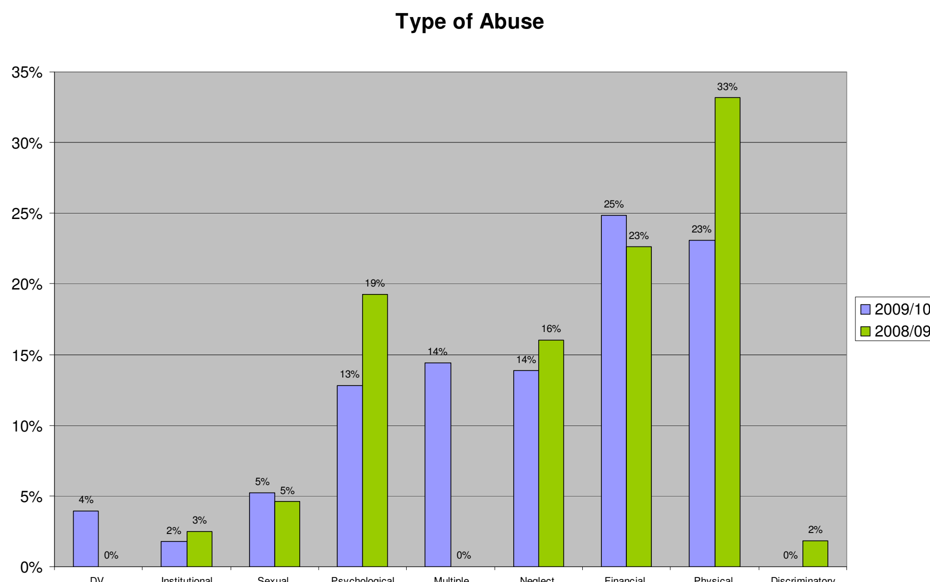
There was also an increase in alerts from voluntary agencies raised 4 alerts in 2008/09 and 16 in 2009/10, an increase both in actual numbers and as a proportion of total alerts (1% in 2008/09 and 4% in 2009/10). This reflects an increased awareness of abuse and the promotion of the safeguarding process amongst voluntary agencies.

Alerts made by a member of an adult social care team or integrated team (learning disability services; mental health services) dropped in 2009/10 to 14% from 32% in 2008/09 and 55% in 2007/08. As adult social care has the lead operational role in relation to safeguarding, a high number of alerts from adult social care or integrated teams is to be expected. The proportional drop in alerts from an adult social care or integrated team is related to the increase in alerts from other sources, particularly vulnerable adults themselves, as awareness of and engagement with safeguarding rises across the borough.

### 1.4.2 Type of alleged abuse

In 58% of the 555 recorded types of abuse (more than one form of abuse may legitimately be recorded for each alert), the type of abuse was either financial or physical. More than one form of abuse may be legitimately recorded for each alert, hence the total record of 555 types of abuse is greater than the 457 alerts. In 2009/10, financial abuse has risen both proportionately and actually from 99 records of type of alleged abuse (23%) in 2008/09 to 138 (25%) in 2009/10 and is now the single largest category of alleged abuse. In 2008/09, the single largest category of alleged abuse was physical, this was the second largest in 2009/10. Alleged financial abuse and physical abuse have comprised the two largest categories of alleged abuse in the last three years.

Two forms of alleged abuse have fallen both proportionately and actually; physical abuse (128 records of type of abuse or 23% in 2009/10 compared to 145 or 33% in 2008/09) and psychological abuse (71 records of type of abuse or 13% in 2009/10 compared to 84 or 19% in 2008/09). Alleged neglect has fallen proportionately but not actually; 77 records of type of abuse or 14% in 2009/10 compared to 70 or 16% in 2008/09. These changes are likely to be a function of the increase in alerts and more accurate recording of the types of alleged abuse and it may also be that there have been actual changes in the type of alleged abuse. For the first time, domestic violence (as per the Multi Agency Risk Assessment Committee (MARAC) definition of domestic violence) was recorded (4%) and 21% of alerts recorded multiple abuse in the main abuse code.



### 1.4.3 Location of alleged abuse

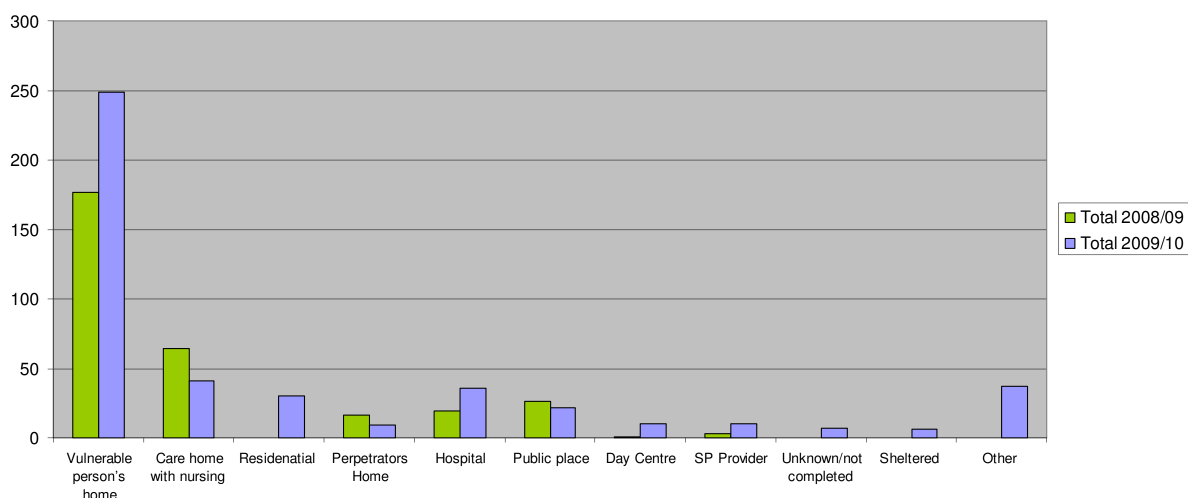
In 54% of the 457 alerts the alleged abuse was stated to have taken place in the vulnerable adults own home.

The location of the alleged abuse was recorded in all cases. In 249 or 54% of the 457 alerts, the alleged abuse was stated to have taken place in the vulnerable adult's own home. This proportion has not changed significantly from 2008/09.

The second most significant location for alleged abuse was care homes. 41 alerts related to care homes with nursing and 30 to residential settings. This includes alerts in care homes (16) and residential homes (19) outside the borough. This is the first time that out of borough alerts have been recorded in the annual report as they are now required to be. In out of borough alerts, the host authority is the chair and lead; Hammersmith and Fulham investigators have a responsibility to participate in the investigation in relation to their service user and Hammersmith and Fulham procurement officers monitor the suitability and safety of the home for all Hammersmith and Fulham residents placed there.

The percentage of alerts relating to alleged abuse within care homes with nursing and residential homes is 15%; this is a continuing fall from 19% in 2008/09 and 25% in 2007/08 and reflect the effective strategic approach taken with providers. If alerts in out of borough placements are removed so as to compare like for like, there were 36 alerts where the alleged abuse took place in a care home or residential home in Hammersmith and Fulham (out of borough placements were not counted in 2008/09), 8% of total alerts. This is a marked decrease from the 19% and 25% of 2008/09 and 2007/08 respectively.

There were 36 alleged incidents of abuse in hospitals or 8% of the total, 17 of which were within Hammersmith and Fulham.




From the annual safeguarding adults dataset, the geographical centre of the postcode of the location of alerts in Hammersmith and Fulham was linked to the Lower Super Output Area (LSOA) which is the national report of deprivation. The percentage of alerts per Super Output Area was compared with the percentage of Super Output Areas in

Hammersmith and Fulham. This then showed the location of abuse in relation to the level of deprivation. 53% of the Super Output Areas in H&F fall into the top 30% most deprived areas nationally. However 65% of safeguarding alerts in H&F were in the top 30% of deprived areas nationally.

### 1.4.4 Alleged perpetrator

In 41% of the 457 alerts the alleged perpetrator was a family member or relative, friend or neighbour.

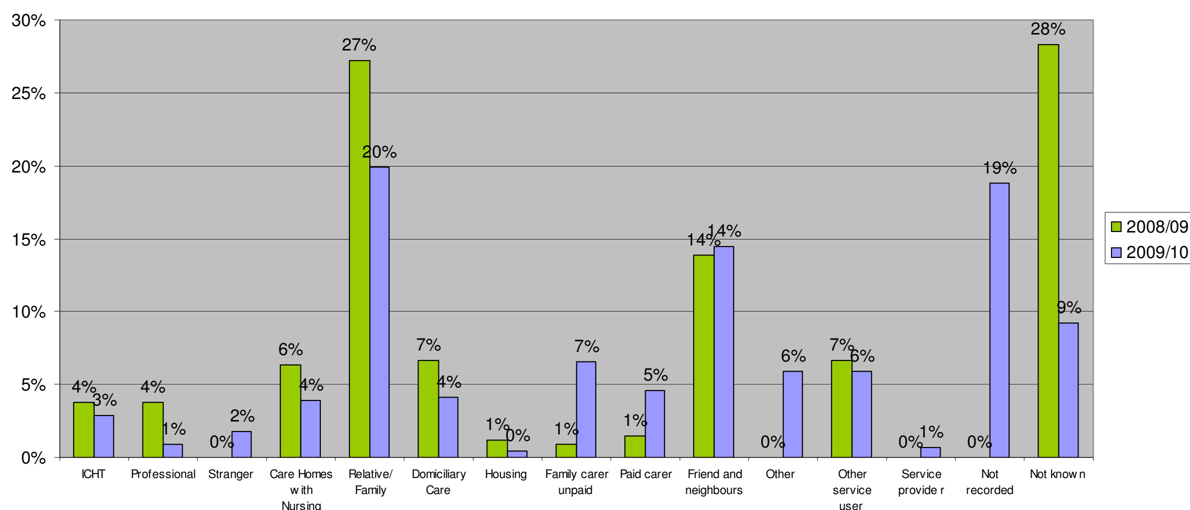
Of the 457 safeguarding alerts, relatives and family were the single largest perpetrator group and accounted for 121 or 26% of alerts. In 2008/09, 94 or 27% of alleged perpetrators were relatives or family members and in 2007/08, 35%. In 29 alerts or 24% of alerts where the alleged perpetrator was a relative or family member, they were an unpaid carer for the person they were alleged to have abused. Of these, 15 alerts had been concluded and 14 had not. Of the 15 that had, abuse was substantiated or partially substantiated in 7 or 46%. Of total concluded cases, 25% were substantiated or partially substantiated. Abuse is therefore substantiated or partially substantiated in a greater proportion of concluded alerts where the alleged perpetrator is an unpaid carer, although the numbers are too low to generalise from with an acceptable degree of confidence. Of the 121 alerts where the alleged perpetrator was a relative or family member, 65% were male, 55% were under 60 and 4% were under 18.

The safeguarding strategy includes a priority on carers and the consultation process will seek to ascertain the views of carers as to appropriate actions both to support the carer and prevent abuse from reoccurring where it has been substantiated or partially substantiated.

The second largest perpetrator group was friends or neighbours (66 or 14%), the same proportion as 2008/09.

In 6% of total alerts the alleged perpetrator was another service user, again similar to 5% in 2008/09.

In 108 alerts the alleged perpetrator was not recorded at the alert stage; at 24% this was slightly lower than in 2008/09 when 96 or 28% of cases the perpetrator was not identified at the alert stage. The reason for this may be that the perpetrator is not known but the reasons for this recording practice will be addressed in the coming year.




### 1.4.5 Safeguarding alerts by gender

Proportion of alerts by gender is 3% different from proportion of adult social care service users by gender, women being under represented by 3%.

In 2009/10, 275 or 60% of safeguarding alerts were for women (55% in 2008/09; 62% in 2007/08; 57% in 2006/07) whereas at any one time approximately 63% of adult social care service users with a known gender are women. Conversely, 181 or 40% of safeguarding alerts were for men (45% in 2008/9; 38% in 2007/08; 43% in 2006/07) whereas at any one time approximately 37% of adult social care service users are men. In 2009/10 the proportion of alerts and the service user profile were closer than in 2008/09 but these proportions have fluctuated over time and do not appear to indicate a trend. The profile for adult social care services does not necessarily reflect the profile were health services from integrated teams included.

### 1.4.6 Safeguarding alerts by ethnicity

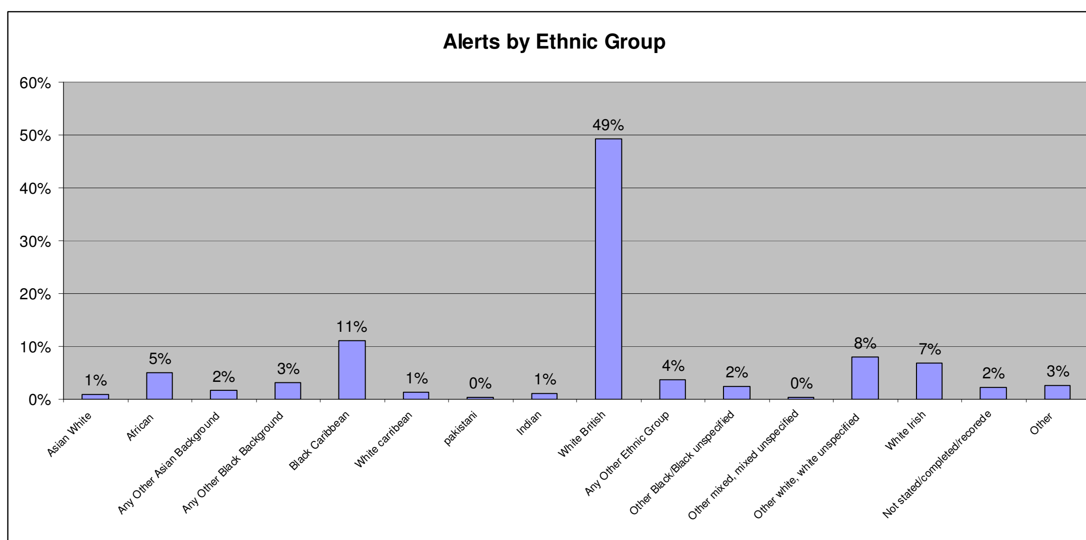
Proportion of alerts from BME groups is more than the proportion of adult social care service users from BME groups.

Ethnic origin was recorded in 435 of the 457 alerts. Of 435 alerts with a known ethnic origin, 143 or 33% were from black and minority ethnic groups (BME) in 2009/10. In 2008/09, 22% of alerts were from BME groups; in 2007/08 16%; and in 2006/07 17.5%.

The 143 alerts from people from BME groups included people who were African (23), Caribbean (57), Indian (5), other Asian background (14). The largest single BME group was Caribbean, 40% of BME alerts and 12% of total alerts.

Approximately 26% of adult social care service users at any one time with a known ethnic origin are from BME backgrounds. Therefore, in 2009/10 the proportion of alerts relating to people from BME groups was more than the proportion of adult social care service users from BME backgrounds. This is likely to be a function of the overrepresentation in alerts from mental health. Of the mental health service users with

an allocated adult social care worker and whose ethnic origin is known and recorded, 44% are from BME groups, higher than the 26% in adult social care.



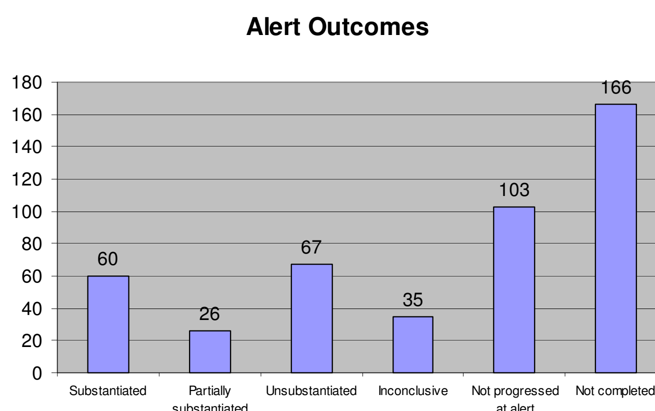

## 2 Safeguarding Practice

### 2.1 Management of safeguarding alerts

#### Investigations

77% of alerts progressed to investigation, 64% of total alerts concluded by March 31st 2010. Mental health is responsible for 31% uncompleted alerts; the Quality Assurance Manager, Safeguarding has raised this with the service and will monitor.

In 2009/10, 354 (77%) of alerts were progressed to investigation. By March 31st 2010, 292 of the 457 safeguarding investigations were concluded either because they were not progressed beyond alert stage (103) or because they were concluded after the process had been applied in its entirety (189). This was 64% of the total 457 alerts for 2009/10. The proportion of uncompleted cases by user group was broadly in line with the proportion of alerts by user group except for mental health which accounted for 31% of uncompleted alerts compared to 24% of alerts. This has been addressed with the service by the Quality Assurance Manager,




#### Outcomes

Of the investigations concluded in 2009/10, 86 were substantiated or partially substantiated, compared to 89 in the previous year. Despite the increase in alerts, the number of substantiated/partially substantiated cases remains virtually the same.

Not all investigations were concluded in year. In 2009/10, of the 457 total alerts, 103 were closed at alert. Of the remaining 354 alerts progressed to investigation, 189 were

concluded as of March 31st 2010. Of these, 86 were substantiated or partially substantiated.

In 2009/10, only those closed cases that were opened in year were analysed. In 2008/09 closed cases were analysed where they had been opened in year and in the previous year as well. The analysis is not precisely like for like but is comparable. Of the 163 alerts that were concluded in 2008/09, 89 were substantiated or partially substantiated.

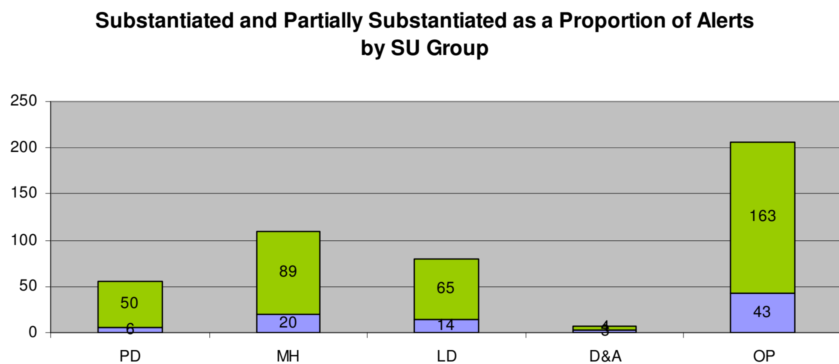
Despite the increase in alerts and the increase in alerts progressed to investigation, there was no change in the number of cases where abuse was substantiated or partially substantiated when comparing March 31st 2009 to March 31st 2010.

**Profile of substantiated/partially substantiated alerts**

The proportion of substantiated/partially substantiated alerts to total alerts was highest for drugs and alcohol (43% of total alerts were substantiated or partially substantiated) and older people (21%). In 67% of substantiated/partially substantiated alerts where the perpetrator was known and recorded the perpetrator was a partner, other family member, family carer, friend or neighbour. In 36% of substantiated/partially substantiated recorded types of abuse, abuse was physical and in 22% of cases the abuse was financial. Of the substantiated/partially substantiated alerts where location of abuse was recorded, 65% of abuse took place in the vulnerable adult's own home.

The percentage of substantiated and partially substantiated alerts by service user group is broadly in line with the percentage of total alerts by service user group. Older people are slightly overrepresented (50% of substantiated and partially substantiated alerts versus 45% of total alerts) and physical disabilities are slightly under represented (7% of substantiated and partially substantiated alerts versus 12% of total alerts). Substantiated and partially substantiated alerts for learning disabilities as a proportion of total substantiated/partially substantiated alerts (16%) were broadly in line with proportion of total alerts (17%). Substantiated and partially substantiated alerts for mental health as a proportion of total substantiated/partially substantiated alerts (23%) were broadly in line with proportion of total alerts (24%).

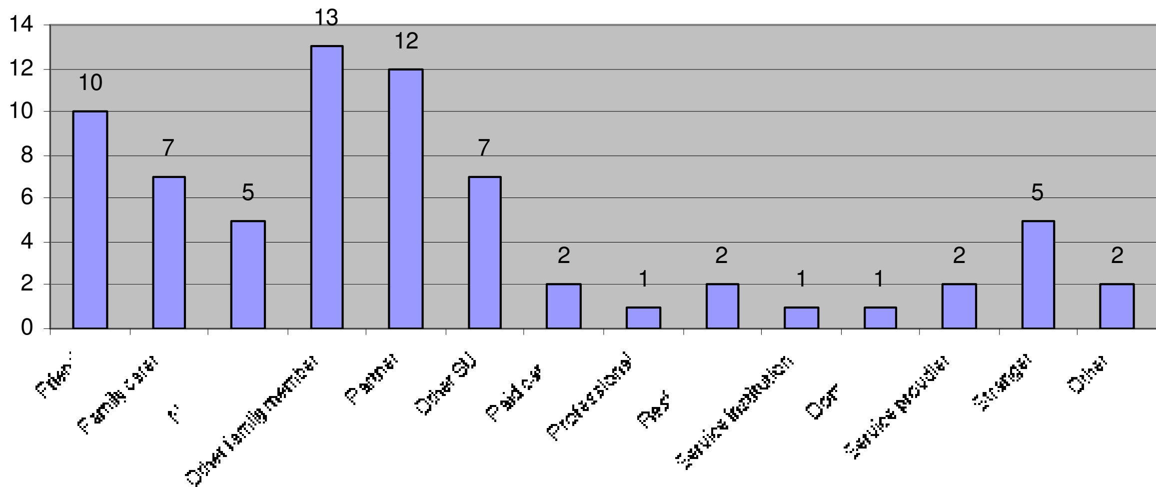
Substantiated and partially substantiated alerts as a percentage of total alerts per service user group vary from 11% of total alerts being substantiated or partially substantiated (physical disabilities) to 43% (drugs and alcohol).




Of the substantiated and partially substantiated alerts where the perpetrator was known and recorded (70 alerts), in 47 or 67% the perpetrator was a partner, other family member, family carer, friend or neighbour. Of the 42 substantiated and partially

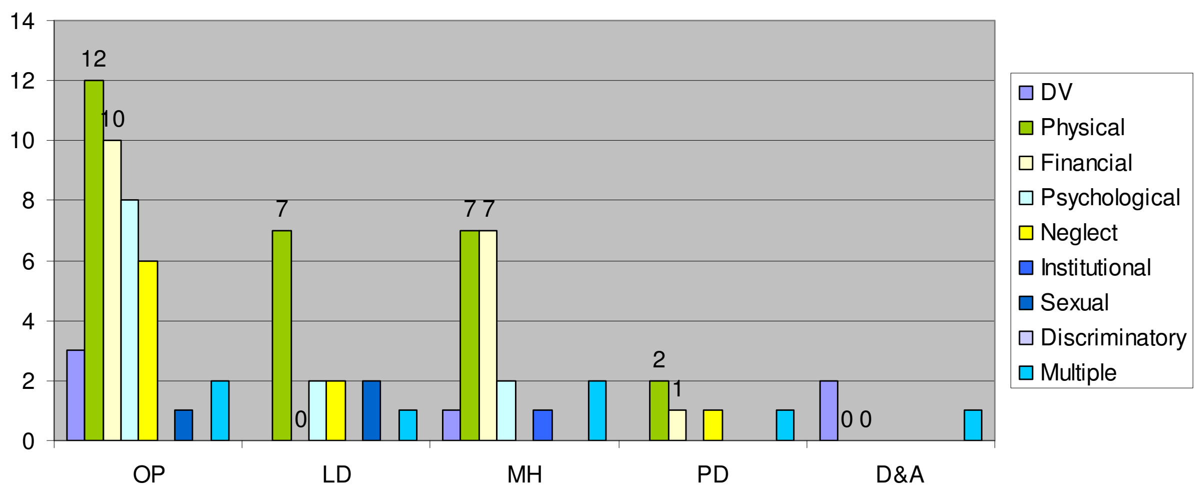
substantiated alerts for older people where type of abuse was recorded (43 in total), the majority were physical abuse (12 or 29%) or financial abuse (10 or 24%).

**Substantiated/Partially Substantiated by Perpetrator**




Of the substantiated and partially substantiated alerts where the type of abuse was known and recorded (96 records of substantiated and partially substantiated abuse legitimately indicated more than one type of abuse), in 34 or 36% of cases the abuse was physical and in 21 or 22% of cases the abuse was financial. Of the 14 substantiated and partially substantiated alerts for learning disabilities where type of abuse was recorded (14 in total), the majority (7 or 50%) were physical abuse. Of the 20 substantiated and partially substantiated alerts for mental health where type of abuse was recorded (20 in total), 7 (35%) were physical abuse and 7 (35%) were financial abuse. Of the 5 substantiated and partially substantiated alerts for physical disabilities where type of abuse was recorded (6 in total), 2 (40%) were for physical abuse but otherwise type of abuse was spread across most categories. Of the 3 substantiated and partially substantiated alerts for drugs and alcohol where type of abuse was recorded (3 in total), 2 were for multiple abuse and 1 was for domestic violence. For most user groups, therefore, physical and financial abuse were the most common types of substantiated and partially substantiated abuse.

Of the substantiated/partially substantiated alerts where location of abuse was recorded, 65% of abuse took place in the vulnerable adult's own home.




The percentage of substantiated and partially substantiated alerts from BME groups was 30%,40 compared to the 33% of total alerts from BME groups. Therefore total alerts and substantiated/partially substantiated alerts were almost in line in relation to ethnicity.

The percentage of substantiated and partially substantiated alerts from females was 60% and from males 40%, compared to total alerts where 60% were from females and 40% from males. Therefore total alerts and substantiated/partially substantiated alerts were in line in relation to gender.

**Safeguarding alerts by team**

**Alerts by team are comparable to alerts by service user group.**

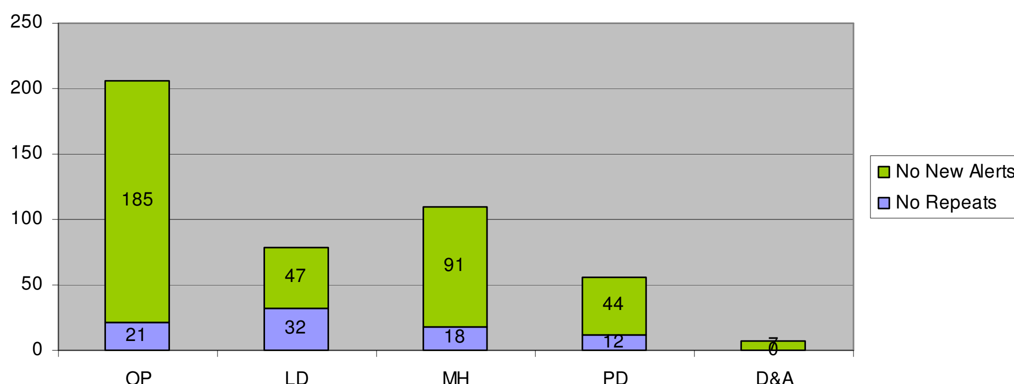
The Older People's Social Work Teams were responsible for managing the single largest number of safeguarding alerts (145, 31%). Taken in conjunction with the Hospital Social Work Team who deal primarily with older people and who managed 63 (14%) of alerts, these teams account for the management of 208 (46%) of safeguarding alerts. This is consistent with the fact that in 2009/10 45% of alerts were for older people.

The CMHTs dealt with 112 or 26% of safeguarding alerts, which again correlates with 24% of safeguarding alerts being for people with mental health needs. There is a close correlation in relation to learning disabilities (17%) and drugs and alcohol services (2%). The physical disabilities team managed 49 or 11% of safeguarding alerts, again broadly comparable to the 12% of alerts for this user group. In summary, there is a direct and close correlation between safeguarding alerts for each service user group and the teams managing the alerts.

**Repeat Alerts**

**18% of safeguarding alerts related to the same 38 service users. 32 of these relate to 14 learning disabled adults, although alerts are no more likely to be substantiated where they relate to learning disabilities than mental health or physical disabilities.**

Of the 457 safeguarding alerts in 2009/10, 83 or 18% are alerts that relate to the same 38 service users. The proportion of alerts that relate to the same service user varies across the service user groups but is highest in learning disabilities where of a total 79 alerts, 32 (41%) pertained to the same 14 vulnerable adults. This may be a function of the service user group but will be further investigated.




## 2.2 Quality assuring safeguarding

Robust mechanisms were in place for quality assuring safeguarding practice. The quality assurance framework for safeguarding was reviewed in year. It was agreed that quarterly audits would be undertaken of 25 cases and of these, one would be an annual audit of 50 cases. The revised quality assurance framework was implemented. Audits included cases where the investigation had been undertaken by a partner agency other than adult social care and integrated teams. In addition, the quality assurance reviews of adult social care and integrated services all included a review of the service against role appropriate safeguarding standards. Lastly, vulnerable adults' experiences of safeguarding practice are an important quality assurance mechanism. Throughout the year, regular interviews were held with people who had been safeguarded and their informal carer where appropriate and the interview outcomes used to inform service developments or quality improvements.

## 2.3 Audit Outcomes

Safeguarding practice has improved considerably since mid 2008 when a baseline audit indicated that practice had been 'adequate' in 8% of audited safeguarding cases and 'poor' in 92%. Intensive efforts to improve safeguarding practice were made throughout the year and a second annual audit in May/June 2009 indicated an initial improvement such that 72% of audited safeguarding cases were 'adequate', 'good' or 'excellent' and 28% were 'poor'. Intensive efforts to improve practice continued and the third annual audit in April 2010 combined with quarterly audits throughout the year indicated that 55% of safeguarding cases were 'adequate', 'good' or 'excellent' (31% being 'good' or excellent) and that 45% were 'poor'. The audits included cases which had been investigated by a range of partners. It is likely that the initial improvement was due to the intense scrutiny at that time and that the current level of performance, sustained throughout the year, is a reflection of the committee's steady, solid current approach, focused on learning and development interventions tied to tighter quality assurance mechanisms. Since the baseline in year one, expectations are higher and quality assurance processes more refined.

In adult social care, significant changes are being put in place to make a further sustainable step change in performance in relation to the management (and investigation) of safeguarding cases. Firstly, the skills mix will change so that care management is no longer a social work function thereby freeing social workers to concentrate on professional practice with safeguarding as a core task. Secondly, team structures are changing to reflect the revised service design such that the supervisor:social worker ratio is far smaller and better able to focus on professional practice. Thirdly, performance management will be invoked where necessary. It is anticipated that a further significant improvement in safeguarding practice will occur over the next year.

## 2.4 Learning and Development

The Safeguarding Adults Committee Training Subgroup led on the commissioning of safeguarding learning and development interventions to address the needs of all partner agencies. In 2009/10 basic awareness training was available to staff at all levels to equip them to recognise, report and refer abuse for investigation. Train the trainer training was provided. An ongoing programme of investigators and managers/chairs training continued throughout the year and in addition training in safeguarding in relation to financial abuse and domestic violence was provided.

To complement the classroom based teaching, intensive team based coaching was provided for chairs and investigators in adult social care and integrated teams. In 2009/10, 18 team sessions took place with older people's social work (6), physical disabilities social work (2), learning disabilities (4) and mental health teams (6). Further sessions will be held. In addition, weekly safeguarding panels were provided as a further learning and development opportunity for chairs and investigators as well as a quality assurance tool.

The range of learning and development interventions were welcomed by chairs and investigators.

## 2.5 Mental Capacity and Safeguarding

As the lead agency for the implementation of the Mental Capacity Act and the Deprivation of Liberty (DOLS) Safeguards, adult social care has developed procedures for the management of DOLS applications. Quality Assurance Managers for both Mental Capacity Act and Safeguarding work closely together to develop practice because the two work streams overlap. In safeguarding, people who lack capacity to understand the allegation of abuse and its associated risks are referred to the Independent Mental Capacity Advocate to ensure the individuals' interests are addressed in the investigation; in 2009/10, four people were referred. The Quality Assurance Team's programme of service reviews includes audits of both mental capacity and safeguarding. Practice is being addressed in both Safeguarding and Mental Capacity Act training and in the team programmes. It is proposed that in order to strengthen The Mental Capacity Act/DOLS Local Implementation Network, that the MCA/DOLS and safeguarding work streams are brought together and shared with the Safeguarding Adults Committee and its Sub Groups.

## 4 Conclusions

The Safeguarding Adults Committee provided effective leadership for the borough's safeguarding policy and practice throughout the year. The committee was regularly attended by all partners and membership grew to include, amongst others, representation from the LINk, Better Government and carers. The four sub groups progressed their respective work programmes.

In 2009/10, Hammersmith and Fulham received 457 safeguarding alerts compared to the 346 received in 2008/09. This was a 32% increase in alerts compared to the 46% increase the previous year and a lower rate of increase than in the previous three years.

2008/09 safeguarding figures for London were published in May 2010. Hammersmith and Fulham received a higher rate of safeguarding alerts in 2008/09 compared to the average London borough but was not an outlier. One or two of the London boroughs experienced a decrease in the number of alerts in 2008/09 compared to 2007/08. All service user groups received a rate of alerts higher than or equivalent to the London average.

In 2009/10, there was a marked increase in the number of alerts from vulnerable adults themselves. In 2009/10, 70 or 15% of alerts were raised by the vulnerable adult; in 2008/09, 23 or 7% and in 2007/08, 3 or 2%. This may be a function of increased awareness of abuse and how to report it amongst vulnerable adults as well as improved recording practice by adult social care and integrated teams.

Partner agencies have made significant progress in raising awareness and developing safeguarding practice. In 2008 partners agreed a model whereby adult social care lead and manage all investigations and investigations were undertaken by specialist professionals from partner agencies. Evidence suggests that this model is still the most effective way to investigate abuse. Work is in progress to ensure that there are sufficient appropriately trained and accredited investigators in each agency.

For the last three years, the two single largest categories of alleged abuse have been financial and physical; this year, financial abuse has been the largest. In the majority of alerts, the alleged abuse was stated to have taken place in the vulnerable adult's own home. The number of cases where the alleged abuse was stated to have taken place in a care home or care home with nursing has remained static and decreased as a proportion of total alerts. In the majority of alerts, the alleged perpetrator was a family member or relative, friend or neighbour. Given these conditions, the increase in self referrals from vulnerable adults is especially important.

A greater number of alerts were closed at alert stage and a greater number of alerts were also progressed to investigation in 2009/10 than in 2008/09. The audit system tests both sets of alerts for appropriate decision making and safeguarding practice.

Despite the increase in the number of alerts and the increase in those progressed to investigation, virtually the same number of vulnerable adults were found to have been abused as of March 31st 2010 and March 31st 2009. In 2008/09 89 alerts were found to have been substantiated or partially substantiated and in 2009/10 86 alerts were found to have been substantiated or partially substantiated.

Alerts were more likely to be substantiated for vulnerable adults in receipt of services from the drugs and alcohol team (46% of total alerts were substantiated or partially substantiated). For older people, 21% of alerts were substantiated or partially substantiated; for mental health and learning disabilities 18% of alerts were substantiated or partially substantiated and for physical disabilities 11% of alerts were substantiated or partially substantiated. In 67% of substantiated/partially substantiated alerts where the perpetrator was known and recorded, the perpetrator was a partner, other family member, family carer, friend or neighbour. In 36% of substantiated/partially substantiated recorded types of abuse, the abuse was physical and in 21 or 22% of cases the abuse was financial. Of the substantiated/partially substantiated alerts where location of abuse was recorded, 65% of abuse took place in the vulnerable adult's own home. That is, abuse is most often physical or financial in nature, is most often caused by a partner, family member, family carer, friend or neighbour and most often occurs in the vulnerable adults' own home. These findings will inform the proposed Safeguarding Adults Strategy.

Of the 457 alerts, 83 pertained to the same 38 vulnerable adults. Learning disabilities had an especially high number of alerts for the same service user; 39% of their total alerts were repeat alerts for the same service user. This may have been a function of the user group, but will be analysed further in 2010/11.

Quality assurance mechanisms were strengthened in 2009/10. Quarterly audits and an annual audit as well as quality assurance reviews and interviews with vulnerable adults who have been safeguarded have all informed safeguarding practice developments. The 2010 audit showed a continued improvement on the baseline audit in 2008; in 2009 55% of cases were 'adequate' of which 31% were 'good' or 'excellent' compared to 2008 when only 8% were 'adequate' and none were better. The 2009 audit outcome of 72% 'adequate' and above and 28% 'poor' was likely to have been the result of intense scrutiny at the time.

The sustained improvement in safeguarding practice combined with the unchanged number of alerts where abuse was substantiated or partly substantiated suggest that a more refined process whereby alerts could be closed after safeguarding strategy as well as at alert stage and at review stage could be usefully implemented, as is accepted practice in some London boroughs. The Safeguarding Adults Committee agreed this change in June 2010. Closure at strategy stage will be subject to the same decision making pro forma as at the review stage. The frameworki workflow and the practice guide will be updated in line with this change.

To date, intensive learning and development interventions have been the main approach to improving practice. In 2010/11, adult social care will be seeking to make a further, sustainable step change in safeguarding practice. This will include a change to the skills mix so that care management is no longer a social work function thereby freeing social workers to concentrate on professional practice with safeguarding as a core task; a change to the team structure such that the supervisor:social worker ratio is far smaller and better able to focus on professional practice and the invoking of formal performance management procedures where appropriate. It is intended that these actions will support the borough in achieving its target of 100% of safeguarding cases managed at an 'adequate' and above level and 60% managed at a 'performing well' and above level.

## Appendix One – Safeguarding Committee Membership

| Name | Role | Organisation |
|---|---|---|
| John Chamberlain | Chair; Assistant Director Adult Social Care | CSD |
| Caroline Kelsall | Quality Assurance Manager, Safeguarding Adults | CSD |
| Angela Jenkinson | Head of Quality Assurance | CSD |
| David Mitchell | Executive Lead in Safeguarding | ICHT |
| Ginny Wright | Consultant Elderly Medicine | ICHT |
| Margaret Fry | Lead Nurse for Medicine/Operational Lead for H&F | ICHT |
| Frances Donnelly | Associate Director of Quality and Safety | H&F NHS |
| Judith Barlow | Director of Services | Central West London Community Services, |
| Raylene Lindsay | Operational Lead for safeguarding | Central West London Community Services |
| Glynn Jones | Detective Inspector, Community Safety Unit | Metropolitan Police |
| Lynda Appleby | Manager | Care UK |
| Teresa Brown | Anti Social Behaviour Unit | LBHF |
| Alistair Wood | | Probation |
| Mary Shepheard | Trustee | Community and Voluntary Sector Association |
| Lindy Shufflebotham/ Tim Hughes | Director | Yarrow Housing |
| Yosief Habtu | Senior Contracts Manager | Lookahead |
| Jane Ray | Regulation Manager | CQC |
| Caroline Frayne | Community drug and Alcohol Services | Central North West London |
| Bryan Naylor | Chair | Older People's Consultative Forum |
| Jean Milloy | Curriculum Skills Manager | Adult Learning & Skills Service, CSD |
| Malika Hamidou/ Karen Lyon | Chair | LinKs |
| Steven Falvey | Senior Commissioning Manager for carers | Strategic Commissing, CSD |
| Harbhajan Purewal | Carer Centre Manager | H&F Carers Centre |
| Carmel Benson | Acting Housing Support Manager | CSD |
| Maire Lowe | Senior Learning and Development Manager | CSD |
| Helen Mangan, | Director, Hammersmith and Fulham | WLMHT |
| Michael Phelan | Consultant Psychiatrist | WLMHT |
| Tim Deacon | Quality Assurance | LBHF Children's Services |
| Kay Fisher | Assistant Head of Procurement | CSD |
| Phil Williams | Head of Services, Learning Disability Team | CSD |
| Ann Stuart | Service Manager, Older People | CSD |

# Appendix Two – Policy Context

## 1.1 NATIONAL DEVELOPMENTS IN 2009/10

'No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse' was published in 2000 by the Department of Health. Following the publication of the findings of the consultation in 2008, the Department of Health is leading the revision and after some delay from the expected launch of 2009, is due in the autumn of 2010.

The Social Care Institute for Excellence is leading the development of Pan London Safeguarding Procedures which are due for release in the autumn, after a re-write by a second. Consultation has taken place with the Association of Directors of Adult Social Services and the London Network of Safeguarding Coordinators and after a brief consultation period for Adult Safeguarding Boards is also expected in the autumn.

Provisions The Safeguarding Vulnerable Groups Act 2006 are being phased in over the next five years. In October 12th 2009 the Independent Safeguarding Authority which was created by the Act introduced two barring lists rather than the Protection Of Children Act (POCA), Protection of Vulnerable Adults (PoVA) and List 99. It also introduced barring from 'regulated activities' including areas of work with vulnerable adults such as the NHS and the Prison Service and a new duty to share information; employers, social services and professional regulators now have to notify the Independent Safeguarding Authority of relevant information so individuals who pose a threat to vulnerable groups can be identified and barred from working with these groups. Safeguarding managers have a new duty to refer the perpetrator to the Independent Safeguarding Authority if the abuse is substantiated at the case conference.

On April 1st 2009, the responsibility for regulation of council and health care and regulated provider agencies transferred from the Commission for Social Care Inspection and the Healthcare Commission to the new Care Quality Commission. Its responsibilities now extend to the NHS as well as Social Services and social care providers. The Care Quality Commission is continuing the programme of inspections in which safeguarding adults plays a significant part.