Belfast Health and Social Care Trust

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Belfast Health and Social Care Trust

Adult Safeguarding

Annual Position Report

2020/21

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SECTION 1: Overview

The Belfast Health and Social Care Trust is committed to promoting the health, well-being and protection of all adults in receipt of its services across the spectrum of its universal and specialist provision including domicilliary and day care services, residential care, nursing home care, supported living and respite care provided by or commissioned on behalf of the Trust.

The annual Adult Safeguarding Position report reviews three core themes contained in Adult Safeguarding Prevention and Protection in Partnership Policy (2015) and Operational Procedures (2016): *Prevention, Partnership and Protection*.

The annual report for 2020/21 provides an overview of assurance arrangements, commentary in relation to challenges and achievements relating to Adult Safeguarding throughout the Belfast Health and Social Care Trust, service area reports and adult safeguarding data activity. In addition the report provides updates in relation to the Adult Safeguarding Committee Action Plan 2020-21.

The last year has seen a number of operational and strategic challenges alongside developments in Adult Safeguarding.

These include:

- The impact of Covid-19 on operational and strategic adult safeguarding
- Transitioning of operational and strategic practices onto a virtual platform
- Refocus on Belfast Trust Adult Safeguarding Action plan
- Implementation of Belfast Trust Adult Safeguarding Champion support forum
- Partnership progress.
- Prevention initiatives.
- Introduction of the Interim Adult Protection Board

As noted in the previous annual report, the Northern Ireland Adult Safeguarding Partnership (NIASP) officially stood down in December 2019. Belfast LASP progressed Adult Safeguarding at a local level in the absence of strategic direction or an agreed work plan for this reporting period.

SECTION 2: Adult Safeguarding Governance Arrangements

The Belfast Trust operate to the Regional Adult Safeguarding: Prevention and Protection in Partnership Policy (2015), Regional Adult Safeguarding Operational Procedures (2016) and the Regional policy Protocol for Joint Investigation of Adult Safeguarding Cases (2016) and local Belfast Adult Safeguarding Policy and Procedures.

Trust Governance Arrangements

The Executive Director of Social Work has accountability for the assurance of arrangements pertaining to the delivery of the Trust's statutory functions, including Adult Safeguarding. The Executive Director of Social Work is supported by the Belfast Trust Adult Safeguarding Champion in relation to adult safeguarding work. In September 2020, the TASS was appointed as the Trust interim Adult Safeguarding Champion. The director of Adult Services who was previously the Adult Safeguarding Champion retired.

The Operational Directors are accountable for the service delivery response to safeguarding matters within their respective Directorates.

Trust Adult Safeguarding Committee

The Trust Adult Safeguarding Committee's principal remit is to ensure that the Trust meets its obligations in relation to Adult Safeguarding and to provide the necessary assurances with regard to its responsibilities in respect of this.

The Belfast Trust Adult Safeguarding Committee is chaired by the Executive Director of Social Work and coordinated by the Trust Adult Safeguarding Specialist. In this reporting period the Adult Safeguarding Committee has continued to meet on a quarterly basis, with meetings taking place on 8/10/20, 3/12/20, 7/1/2021 and 11/3/21.

While the Trust Adult Safeguarding Specialist continued to support the work of the Adult Safeguarding committee, given other work commitments, the temporary Adult Safeguarding Development post has remained in situ. This has facilitated the development of a more detailed Belfast Trust Adult Safeguarding Action Plan and progression of work streams.

In April 2020 the Trust Adult Safeguarding Specialist took on operational senior management responsibility for Muckamore Historical Adult Safeguarding Team which, is a part of the broader Historical Abuse investigation team.

LASP Governance Arrangements

The Belfast LASP is a multi-agency group that continues to meet on a quarterly basis. Previously the Belfast LASP would have delivered on strategic prioritises as detailed

in the NIASP Strategy and annual Action Plan alongside any additional areas considered to be a priority by the LASP. However, with the review of adult safeguarding structures in Northern Ireland and the establishment of the Transformation Board and the Interim Adult Protection Board, Belfast LASP work is currently focusing on local priorities in the promotion of prevention and early intervention.

Operational Arrangements

Within the Adult Services directorate in the Belfast Trust, operational arrangements for the management and coordination of Adult Safeguarding and Adult Protection remain in place, with each service area having specialist adult safeguarding staff undertaking the roles of Designated Adult Protection Officers and Investigating Officers.

Within the Belfast Trust the following arrangements are in place regarding adult safeguarding service delivery:

Adult, Community and Older People Service

The Adult Protection Gateway Team (APGT) is now in its eighth operational year and continues to provide a gateway / protection response for the Older People (OP) service area and Physical and Sensory Disability (PSD) service area. The APGT operate a two tier function to provide a central point of contact for external referrals and facilitates all adult protection investigations for all referrals for OP and PSD meeting the 'Adult in Need of Protection' threshold. For referrals that require a protection response cases are allocated to APGT DAPOs and IOs for investigation. To provide this service the APGT has the following compliment of staff: B8A Assistant Service Manager, B7 DAPOs, B6 IOs and 1 B7 Nurse Specialist.

Physical Health & Sensory Disability and Older Peoples Service have a fundamental role in relation to managing 'adult at risk of harm' referrals through the provision of alternative safeguarding responses, professional assessment and risk assessment. The community teams within the Older Peoples services and Physical Health and Sensory Disability services also have specialist trained adult safeguarding staff as Designated Adult Protection Officers and Investigating Officers.

Acute Hospitals

Acute hospital settings within ACOPS have a multi-faceted role in adult safeguarding. Acute hospitals receive referrals from a range of hospital departments, screen referrals and transfer referrals to the relevant service area, team or Trust. The Social Work

Department for acute hospitals have specialist trained adult safeguarding staff as Designated Adult Protection Officers and Investigating Officers.

Mental Health Service

Mental Health adult safeguarding structures operate a localised adult safeguarding team, which consists of one Adult Safeguarding Lead (8a) and two DAPOs who conduct complex adult protection investigations for teams who require DAPO involvement and investigations meeting a specified adult protection criteria.

Mental Health Adult Safeguarding is managed within a localised adult safeguarding team, community teams and hospital teams where the aligned DAPOs screen adult safeguarding referrals, determine the threshold of significant harm and ensures an appropriate response. The DAPOs work to the regional policy applying the threshold to all adult safeguarding referrals in relation to the threshold of 'Alternative Safeguarding Response', 'Adult at risk of harm' and an 'Adult in need of protection'.

Within Adult Mental Health services the Adult Safeguarding team, community teams and Hospital Social Work teams all operate to the Joint Protocol.

Learning Disability Service

Learning Disability Adult Safeguarding secured funding for a permanent designated Adult Safeguarding Lead (8A) post across Community and Hospital Adult Safeguarding. This post continues to play an important role in the management of Adult Safeguarding within Learning Disability Services.

Learning Disability community social work team managers are trained as DAPOs and undertake the DAPO function to screening and investigate adult safeguarding referrals. Community Social Work and Nursing staff are trained as Investigating Officers and undertake the function of IOs in community settings.

Muckamore Abbey Hospital has a dedicate social work team which includes staff trained as DAPOs and IOs.

SECTION 3: Reporting period Achievements and Challenges

This report will highlight the challenges experienced and developments achieved over the reporting period April 2020-March 2021.

- Protection
- Partnership
- Prevention

Protection Work in the context of the Covid pandemic

COVID-19 has had a significant impact upon the delivery of Health and Social Care services across the region, resulting in changes to Belfast Trust delivery of adult safeguarding services and operational day-to-day adult safeguarding work.

Regionally it was acknowledged that Adult Safeguarding and Adult Protection are essential services and Belfast Trust recognising the importance of this work, sustained delivery of the service throughout the pandemic. Lockdown measures instigated in March 2020 changed how staff worked, service user experience of Trust services and modification of communication between staff, stakeholders and those in receipt of Belfast Trust services. Belfast Trust Adult Safeguarding quickly transitioned to working remotely and via virtual platforms, delivering meetings such as Case Conferences and Strategy meetings online rather than face-to-face. With the prompt implementation of digital platforms to support communication and engagement with others, a positive point to note was the prompt expediting of such meetings.

Adult Safeguarding within the Belfast Trust moved into continuity / surge planning. Within the context of the surge plans, adult safeguarding teams across the Belfast Trust continued to assess and monitor the needs and demands to sustain service delivery.

Adult safeguarding trained staff adhered to Health and Safety legislation and COVID-19 Regulations. Adult safeguarding staff embraced the use of PPE, this resulted in challenges when conducting Pre Interview Assessments and Achieving Best Evidence interviews due to the use of face coverings and required robust risk assessments to enable service user and carer face to face meetings.

The Belfast Health and Social Care trust continued to delivery Adult Protection, screening, allocation and investigations in line with the Regional Policy and

Operational Procedures. Although, the Trust modified ways of working moving from face to face contact and meetings, to delivery of such meetings via digital platforms.

An analysis of the data collated for the HSCB for the first quarter of 2021, identified a reduction in referrals from the previous reporting period. In response, the Divisional Social Work Leads approved an interim arrangement, of centralising referrals for **all** Regulated Care Homes to a single point via the Adult Protection Gateway Team. The introduction of this interim measure took place in May 2020 with the Adult Protection Gateway Team were accountable for screening ACOPS regulated care homes and transferring referrals for screening to Mental Health and Learning Disability Adult Safeguarding. The centralised database enabled a collation of data at a central location.

Covid-19 had a significant impact upon staffing levels over this reporting period with service areas at various points experiencing staff absences. With staff absences, service areas such as Learning Disability and Adult Mental Health provided support across divisions when required. This was mitigated by Trust contingency arrangements therefore this did not impact or cause delay to the response and quality of intervention provided.

The Adult Protection Gateway Team, supported community teams as an interim arrangement when a need was identified. Although designated Adult Safeguarding staff were not redeployed, a contingency arrangement was utilised to sustain delivery of Adult Protection.

Joint Protocol:

Referrals requiring a Joint Protocol consultation with PSNI increased by 9% this reporting period with 417 joint agency consultations completed. However the number of referrals agreed as joint investigation was 67. Furthermore, the number of referrals going forward for PIA and ABE remain low with a total of 10 ABE's completed over this reporting period.

It is important to note that this reduction in referrals meeting the threshold for Joint Investigation and subsequent reduction in PIA's and ABE's was consistent with previous years. It is with note that the reduction in Joint Protocol activity is regional trend and is being looked at as part of the regional Joint Protocol work stream.

As a result of repeat trend, the Belfast Adult Safeguarding Strategic Team reviewed the internal arrangements and management of Joint Protocol: PIA and ABE within BHSCT, this resulted in the review of demand and equity of training provision across all Adult Safeguarding Teams within the Trust. The management of PIA's and ABE's and operational refresher requirements continues to sit within each Division; however, the governance of training needs remains the responsibility to the Learning and Development Team and Strategic Adult Safeguarding.

The NIASP works stream responsible for the review of the Joint Protocol review was placed on hold following the cessation of NIASP in 2019. The introduction of the Transformation Board and Interim Adult Protection Board in 2020, allowed for a consideration of the work held pending from the NIASP work stream. The Review of the Joint Protocol was recognised as a significant piece of work which needed to be taken forward. As an interim first step, the Transformation board approved one of the Joint Protocol documents, which had been updated, the AJP3. The approval of the AJP3 form by the Transformation board allowed for regional implementation which was positively received.

Proposed Legislation:

On the 20th September 2020, the Health Minister of Northern Ireland announced a pledge to deliver an Adult Safegaurding Bill for Northern Ireland. The introduction of a potential Adult Safeguarding Bill in Northern Ireland stems from the recommendations of the CPEA independent review of Adult Protection in Northern Ireland. The Department of Health formally confirmed the stepping down of NIASP and announced the introduction of the Transformation Board and Interim Adult Protection Board.

In December 2020, the Department of Health commenced a public consultation on the Draft Adult Protection Bill legislative options. Belfast Health and Social Care Trust provided a collective response in relation to the public consultation in April 2021. The Trust Adult Safeguarding Specialist and Adult Safeguarding Development Officer delivered a series of engagement sessions within the Trust in the last quarter of the reporting period 2020/21. The collective response identified that Belfast Health and Social Care Trust would welcome the implementation of an Adult Protection Bill.

Trust Adult Safeguarding Structures:

Work in relation to a review of the Trust Adult safeguarding structures was initially triggered in response to the regional Adult Safeguarding Policy & Procedure requirement for a single adult protection gateway service. The Trust had established a single point of entry for all external adult safeguarding referrals via the APGT but recognised a need to consider further whether there should be one adult protection gateway services which would be the central point of referral for all adult protection referrals and also carry out all adult protection investigations.

Over a period of years there were several meetings to consider this. There has been analysis work undertaken, options papers completed and various views expressed by a number of senior managers. In addition to the consideration of the operational arrangements for delivery of an adult protection gateway service, work had included

discussions in relation to how adult safeguarding governance and assurance arrangements could be strengthened.

It is important to note that the existing arrangements, where each service area is operationally accountable for delivery of adult safeguarding and adult protection and for all associated governance arrangements, remained in place during this consultation process. Indeed, adult safeguarding arrangements in each service area were tailored to meet the identified service area need and to ensure compliance with adult safeguarding policies and procedures.

PARTNERSHIP:

The Belfast Local Adult Safeguarding Partnership continued to meet on a three occasions over this reporting period. All Belfast LASP meetings took place on a digital platform and enabled LASP members to engage with the interim Trust Adult Safeguarding Champion and receive updates in relation to Adult Protection developments in line with the Transformation Board and interim Adult Protection Board.

The Belfast LASP members reported feeling displaced within the new regional Adult Safeguarding structures. While members continued to express an commitment to LASP they reported a sense lack of regional strategic direction.

The LASP Chair articulated the perspectives of the Belfast LASP at the regional platforms. Both the transformation board and interim adult protection board stressed that the LASP continue to have a fundamental role in the prevention and early intervention of Adult Safeguarding and this remains a critical component of the safeguarding continuum.

BHSCT Trust Adult Safeguarding Specialist, with the addition of the Trust Adult Safeguarding Development Officer continued to maintain partnership working with their counterparts at a regional level with frequent meetings taking place virtually over this reporting period. The regional forum chaired by the HSCB has remained in place and continues to be chaired by the HSCB Adult Safeguarding Regional Officer.

This reporting period enabled a refocus on the Trust Adult Safeguarding Action plan. This action plan focuses on a number of key priorities across operational and strategic aspects of Adult Safegaurding within BHSCT. The area of achievements include:

Adult Safeguarding Training:

The Learning and Development team continued to deliver Adult Safeguarding training, however the method of delivery changed from class room based training in a face to face environment to delivery via MS Teams. This was successful over this reporting period.

Furthermore, Learning and Development Team commissioned the development of Level 1 Adult Safeguarding Training animation. The animation was developed by Orion in partnership with BHSCT. The level 1 training is delivered as part of BHSCT Corporate induction and available for all BHSCT employees to access via the Trust Intranet.

Adult Safeguarding Training Needs Analysis:

There was a significant piece of work completed by the learning and development manager and the strategic Adult Safeguarding team to review the of Belfast Trust adult safeguarding training needs in line with the NIASP and NIPEC Training strategy.

While it was acknowledged, that, each service area and profession were responsible and accountable for their own delivery of Adult Safeguarding training. The work undertaken identified gaps in delivery and accessibility of level 2 and level 3 Adult Safeguarding for professionals outside the Social Work and Social Care workforce, which receive Adult Safeguarding Training from the Trust Learning and Development Team. This piece of work supported the Learning and Development Team to prepare a paper for additional monies to meet the identified learning and development needs in relation to Level 2 and Level 3 Adult Safeguarding Training.

Adult Safeguarding Leadership Meetings:

The Trust Adult Safeguarding Specialist re-established regular Adult Safeguarding Leadership meetings. These meetings took place with representatives from all Adult Safeguarding services. The remit of the Adult Safeguarding Leadership group was to take forward the Adult Safeguarding Committee action plan. In addition, the leadership group were responsible for identifying any operational or strategic issues, which were impacting upon Adult Safeguarding service delivery.

Adult Safeguarding Governance:

The Trust Adult Safeguarding Specialist and Adult Safeguarding Development Officer undertook areas of review in line with regional and local Adult Safeguarding Policy and operational procedures.

- The process of Adult Safeguarding Data retrieval was reviewed and streamlined.

- Trust wide Adult Safeguarding data analysis were presented to the Trust Adult Safeguarding Committee to highlight areas of activity and areas requiring development.
- A centralised data base for Adult Safeguarding Trained staff within BHSCT was created and updated quarterly
- Auditing processes commissioned
- Paris- work recommenced in relation to ensuring the APP suite of forms were developed on Paris CIS. January 2021 a new project management group commenced to develop and implement the regional forms on Paris.

Work was ongoing in relation to a proposal paper in relation to Adult Safeguarding structures, which included a recommendation to strengthen the current governance structure by centralising a number of core governance tasks in a dedicated adult safeguarding governance team.

Adult Safeguarding in Hospital settings:

In response to RQIA inspection reports and recommendations, the Adult Safeguarding Committee action plan included work in relation to Adult Safeguarding in hospital settings.

A task and finish group was established to take forward the RQIA recommendations & learning from outpatients and MAH.

In response to issues raised regarding the processing of APP forms by acute hospital departments though to Hospital Social Work. The group initially focused on a scoping exercise and a Data IT options appraisal paper.

These were presented to the Trust Adult Safeguarding Committee. At the end of the reporting period 2020/21, it was agreed a potential IT solution, would be the development of a 'Power APP' for nurses within Acute hospital wards to process an APP1 referral form. The IT solution identified advantages in relation to standardising referral pathways, gathering data and intelligence and governance arrangements.

Support Networks- Internal and External:

Over the reporting period 2020/21, the Adult Safeguarding Development Officer and Trust Safeguarding Lead trainer identified the need for support networks for External and Internal Adult Safeguarding Champions. Following an extensive scoping exercise, In January 2021, the ASG Development officer and ASG lead trainer developed and established the first Adult Safeguarding Champion Forum for external agencies within Belfast Trust catchment area. The ASC Forum was well attended and positive feedback received. The ASC forum will be delivered on a quarterly basis.

Following the implementation of this support group, an emerging need was identified for a Trust internal Line Manager Support Forum. At the end of this reporting year, arrangements were in place to deliver the initial meeting in spring 2021.

DAPO and IO Forums:

The quarterly DAPO and IO Support Groups continued to take place over this period. The Learning and Development team reported an increase in attendance and engagement by DAPO's and IO's following the transitioning onto a digital platform. Staff and Managers reported the ability to move online has increased engagement across all Adult Safeguarding Staff.

MARAC/ Domestic Abuse:

There were regional concerns that Covid-19 lockdown measures may increase the likelihood and or frequency of domestic and sexual abuse. This led to media campaigns and a Trust renewed focus on this important aspect of work.

Over the twelve month period, significant pieces of work was completed to support staff to accurately record HSCB Data returns, which would reflect the activity of Domestic and Sexual Violence in Belfast Health and Social Care Trust. It is important to note that the annual HSCB Adult Safeguarding Data indicate that the Belfast Health and Social Care Trust responded to over 379 incidents of Domestic and Sexual Violence referrals over the reporting period 2020/21 compared to a recorded number of 61 in 2019/20. It is difficult to definitively state if the data increase relates to accuracy of recording or a high number of domestic and sexual violence incidents. It will be helpful going forward more consistency in recording of Domestic and Sexual Violence referrals, and this will allow for greater data analysis and action planning moving forward.

That said, it is important to note, the increase in Domestic and Sexual violence referrals reflects the PSNI data of increased Domestic Abuse in Northern Ireland over the first 12 months of the pandemic.

MARAC continues to take place on a fortnightly basis chaired by the PPU Detective Sargent. MARAC reps within Adult Safeguarding are located within four services, Learning Disability, Mental Health, APGT and PHSD. MARAC migrated onto a digital platform in March 2020 and continued to take place virtually over the reporting period. Domestic Abuse referrals increased within Belfast Health and Social Care trust compared to the previous reporting year.

Adult Safeguarding within Belfast Health and Social Care Trust continue to engage with working groups such as the Marac Operational Board and Marac Operational Group.

December 2020 saw the introduction of Domestic Homicide Reviews in Northern Ireland. Belfast Health and Social Care Trust welcome the introduction of DHR's and strive to develop the interface between DHR's and Adult Safeguarding processes. As per regional agreement, Belfast Trust identified a small number of senior staff to be trained to deliver on DHR as panel members. Belfast Trust Social Work representatives have participated in DHR throughout the Region. The Trust await with interest the recommendations from DHRs currently underway, and will work to ensure the learning is understood and informs future practice.

Pressure Damage:

One of the current challenges continues to be the issue of management of pressure damage and whether this should be managed through a clinical framework or Adult Safeguarding Process. Some initial regional work took place, which Adult safeguarding contributed to, with an agreement that PHA would take this forward. As a result of COVID19, a number of regional work streams were paused, these include important work on the interface between Pressure Damage and Adult Safeguarding. Although, on hold, operationally, the Trust continue to experience challenges with the interface between Pressure Damage and Adult Safeguarding Processes, this continues to be managed on a case by case approach between Adult Safeguarding and colleagues within Tissue Viability services within the BHSCT.

Human Trafficking & Modern Slavery:

The Trust Adult Safeguarding Specialist remains the Trust representative on the DoJ NGO Engagement Group in relation to Human Trafficking and Modern Slavery. However, due to COVID-19 and other competing operational priorities, the TASS has not been in a position to attend all meetings. That said, the Belfast Trust Adult Safeguarding Development Officer and TASS responded to the testing of a Northern Ireland E learning module for First Responders as requested by the Department of Justice.

Volunteer Now:

Volunteer Now continues to be a core member of the Belfast Local Adult Safeguarding Partnership (LASP) and regularly provides updates in relation to training and developments. Volunteer Now continue to deliver on their regional contract to provide

Adult Safeguarding training. Within Belfast Trust Volunteer now delivered four training sessions as per contract and feedback received outlines positive response.

Policing and Community Safety Partnership (PCSP):

The Belfast Trust Adult Safeguarding Specialist (TASS) continues to be the Trust representative on the South Belfast DPCSP and has continued to highlight the role of PCSP in relation to the Prevention and Protection in Partnership Policy.

Interface with Human Resources:

The complexities in adult protection investigations have resulted in ongoing challenges in relation to the interfaces between adult safeguarding and HR processes where the allegation relates to a staff member.

In the event of an adult protection investigation involves a staff member, there is the requirement to consider the parallel processes which take place and which takes priority. For example, an adult protection investigation will take precedent, to enable protection planning and intervention, however a police investigation may also take place. In addition, the managerial responsibility cannot be overlooked as a referral to a regulatory body maybe required and possible internal and disciplinary processes. Belfast Trust Adult Protection investigations continue to receive requests for Adult Protection reports to assist other investigative processes.

To date the Trust has been addressing these on a case by case basis and has been seeking HR and legal advice as required. The Trust will commit to agreeing a consistent approach throughout Belfast Health and Social Care Trust regarding this interface.

PREVENTION:

Adult Safeguarding Champion Forum for External Agencies:

Belfast Adult Safeguarding Development Officer alongside the Trust Adult Safeguarding Training Lead implemented a formal support network for Adult Safeguarding Champions associated with Regulated Care facilities within the Belfast Health and Social Care Trust catchment area. The first meeting took place in January 2021 via a virtual platform. This established group will focus on sharing of information, identifying and addressing operational and strategic challenges in addition to facilitating peer support.

BHSCT intend to deliver Quarterly Adult Safeguarding Champion Forums.

Position Reports:

The Adult Safeguarding Champions for external regulated care facilities continue to complete annual position reports. The ASC forum has provided support and guidance to ASC's in relation to this. The primary function of the ASC position report is for organisations to ensure regional Adult Safeguarding policy and procedures are followed and responsibilities are understood and implemented within their respective organisations. In this respect this is an accountability report in relation to Adult Safeguarding for any organisation.

BHSCT is currently not resourced to review all external agencies ASC position reports, but can request reports at any stage.

Keeping you Safe Programme:

Despite covid-19 Volunteer Now, continued to deliver their contracted training sessions within the Belfast LASP area. Volunteer now have moved the training onto a virtual platform to ensure delivery of service.

Awareness Raising:

Over this reporting period, Adult Safeguarding Development officer initiated a series of Awareness raising campaigns. These included:

- Social Media Adult Protection Video
- Service User and Staff Posters 'Adult Abuse & COVID19'
- Awareness Raising and referral pathways for GP's within Belfast Health and Social Care Trust Catchment area.
- Adult Safeguarding Awareness Weeks November 2020

SECTION 3 (B) Service Area Reports (direct lift from DSF)

Adult Safeguarding

The Trust has continued to prioritise Adult Safeguarding during the reporting period and has placed this area of work on its Principle Risk Register given the concerns that have been highlighted by RQIA over the past year in respect of a number of facilities eg Shannon Clinic, Meadowlands, Valencia. An action plan has been developed by the Adult Safeguarding Committee to address these deficits in respect of the following: staff awareness of safeguarding policy and procedures, training of the workforce, recruitment of specialist adult safeguarding positions in some divisions, supporting the shared learning across the Trust where practice has improved e.g. Outpatients and Muckamore Abbey Hospital and collation of timely data.

The Trust has experienced challenges with regard to the recruitment of staff to specialist posts such as DAPOs and IOs particularly from within the Learning Disability Programme of Care. To address some of these deficits it has been agreed that the recruitment of future Team Leader posts within this service will now be designated SW posts, who will also undertake the role of DAPO. Currently there are additional pressures on the existing resource to the extent that demand is greater than the capacity of the ASG staff and this has caused ASG staff to be under significant stress which in turn impacts on retention of staff to these posts.

Adult Safeguarding in Muckamore Abbey Hospital:

A significant amount of work has been undertaken in respect of the Safeguarding Improvement Notice that was issued my RQIA in 2019 with the result that it was lifted in April 2020. The detail of the work undertaken is outlined in Section 2.5 of the Learning Disability Report and details the following: the development of new materials to support staff to understand their responsibilities in respect of adult safeguarding; the embedding of safeguarding into everyday core business through safety briefings, weekly ASG meeting; the development of an extensive data set providing information regarding safeguarding incidents, use of seclusion and use of restraint; and the introduction of regular audits.

Learning Disability:

1. RQIA Safeguarding Improvement Notice in Muckamore Abbey Hospital

RQIA placed a safeguarding improvement notice on the Adult Hospital in 2019 with recommendations covering a range of areas including: improving staff awareness re adult safeguarding procedures; making adult safeguarding referrals; implementation of protection plans; improving information sharing with key stakeholders; effective management oversight arrangements and implementing good practice across the hospital site.

Following a significant amount of work this improvement notice was lifted in April 2020. This work included:-

- Additional Training.
- Development and implementation of Aide memoires, new templates, flowcharts, escalation plans and noticeboards.
- Embedding ASG and Protection Planning across the hospital site e.g. through Daily handovers, safety briefings, PIPA, Weekly ASG MDT meeting, live governance, ward managers meeting, monthly ASG Forum, Clinical governance meeting and SMT meetings.
- Establishing a weekly ASG MDT meeting in each ward to discuss new and review existing referrals.
- Establishing a Monthly ASG Forum- to learn collaboratively in respect of ASG investigations through sharing outcomes, good practice, learning from CCTV viewing, sharing outcomes of audits etc.
- Developing an extensive ASG data base- to enable an analysis of ASG data to establish trends/ patterns to inform MDT team, live governance, ward managers meeting, Safety Report for SMT.
- Completion of regular audits to ensure compliance.
- Rolling out of preventative work i.e. keeping yourself safe programme.
- Completion of pre and post ASG questionnaires to receive real time feedback from carers to understand better if intervention is improving outcomes for service users.
- CCTV continues to be live across the hospital site.
- Contemporaneous viewing of CCTV also takes place- areas of good practice and areas for learning are fed back to the staff, and a new quality assurance process has been developed.
- Establishing interface meetings with PSNI and designated PSNI officers identified for the hospital site.
- Commissioning work from Association for Real Change (ARC) to :
- Carry out a baseline assessment in Muckamore Abbey Hospital utilizing a number of different approaches and techniques, including group work and 1:1 support, to explore how safe and happy patients feel in Muckamore. Progress with this has been slow due to COVID but this is now near completion. A report will then be developed to support future planning for patients.
- Carry out post incident ASG investigations with patients, to explore the impact of response, support offered and aftercare. This will include the completion of the questionnaire the service area has drafted which will be amended by ARC- due to COVID this has been temporarily placed on hold.
- Deliver the Keeping You Safe Programme to all the remaining patients within the hospital, who the social work team have been unable to deliver the programme to, including those with communication needs- due to COVID this has been temporarily placed on hold.

Unannounced RQIA Inspection Report in Muckamore on 27 and 28 October 2020 - report received 05/03/21.

There were a number of QIPs as outlined in the previous section and one related to safeguarding which was as follows-

The Belfast Health and Social Care Trust shall ensure that a communication plan is developed which provides clarity to all staff about the information provided to the NOK following an incident, the date and by whom the information was provided, the NOK's response to the information, and the follow up arrangements planned. This information should be recorded in a standardised manner across the hospital site.

The actions to address this are as follows:-

- An escalation plan is in place outlining whose responsibility it is to notify the next of kin of an incident during working hours and outside working hours following an Adult Safeguarding referral.
- To ensure consistency of the information being shared with next of kin by ward staff, the Adult Safeguarding team has developed guidance which has been shared with the Service Manager, Assistant Service Managers and ward staff.
- In addition, the Adult Safeguarding team along with the operational management are in the process of agreeing a template, which will be completed and placed in the patient's file and on the electronic PARIS record. This will include the details of what information has been shared with the next of kin following an adult safeguarding incident, by whom, the date of the incident, the date the contact with the next of kin was made, the response of the carer and what follow up arrangements have been in place - by whom and by when.

2. Adult Safeguarding workforce issues

There are significant workforce issues in the service area in relation to the adult safeguarding workforce.

Currently the Learning Disability Service has a limited resource of DAPOs and IO's.

The 8a ASG Lead post has been vacant despite several attempts to recruit. Fortunately, we were recently successful in recruiting the 8a ASG Lead and he is due to start 1st June 2021.

Most of the DAPO's in the service area are also Team leaders/ Senior Social worker. Adult safeguarding is only a small part of their substantive posts. This puts additional pressure on them as they are also undertaking other keys functions e.g. managing a MDT, chairing PQC meetings, undertaking ASW roles etc.

Due to the current difficulties in relation to safeguarding the service area has agreed that the recruitment of future Team Leader posts will now be designated SW posts.

Additional funding had been secured through IPTs to permanently recruit an additional Senior Practitioner with DAPO responsibilities and 2 SW with IO responsibilities. These posts are currently being progressed through HRPTS.

We currently have 1x WTE DAPO in post who solely provides in reach into Muckamore Abbey Hospital.

The Learning Disability service area has also recently appointed 3x Senior Practitioners with DAPO responsibilities (Temporary). Two of these staff have only recently been trained as DAPOs and they will continue to carry a complex caseload in the community and now provide in reach into the hospital in relation to ASG referrals. The third Senior Practitioner post (temporary) has only recently been appointed and is yet to be trained as a DAPO and take up post. These Senior Practitioner posts are currently being progressed through HPRTS to be recruited permanently.

Within the hospital, there are a range of staff on patient and patient on patient referrals. Recently there has also been a sizeable increase in the number of historic referrals. These have been generated as a result of the consultation undertaken by the Patient Client Council (PCC) in relation to the Public Inquiry. In addition, the ASG team have been asked to relook at a number of historic ASG investigations to provide assurances to families and service users. This involves resource intensive activities such as the viewing of CCTV, reviewing voluminous records, possibly interviewing staff and maintaining regular contact and support to services users and families.

The ASG staff providing in reach to Muckamore is subject to a higher level of scrutiny than other ASG teams and has additional workload such as the viewing of CCTV, chairing weekly ASG meetings per ward, reviewing voluminous documentation, interviewing staff, involved in the quality assurance process in relation to contemporaneous CCTV viewing etc. Further, given the CCTV historical abuse and the recent increase in historic referrals it is essential that the ASG maintain regular contact with our service users and families.

This has also had an impact on the ASG resource. Only one of the safeguarding posts is a WTE therefore the remaining staff who are adult safeguarding trained are diverted away from other responsibilities to deal with the larger scale adult safeguarding investigations in the community and hospital.

There is also a lack of business support to aid the safeguarding staff to represent data in a meaningful way to show trends and patterns.

The ASG staff also currently has no admin support and no dedicated IO staff.

Currently there are additional pressures on the existing resource to the extent that demand is greater than the capacity of the ASG staff. It has caused ASG staff to be under significant stress. It could place patients, families and staff in Muckamore Abbey at risk and potentially risk the Trusts reputation as it is compromising ASG ability to fully undertake the role and carry out robust investigations in a timely manner. It could also potentially mean that Protection Plans may be in place for delayed periods of time for both patients and staff or insufficient protection plans are in place until CCTV viewed or investigation underway.

The viewing of CCTV footage is a very time consuming process and therefore with insufficient resources this can cause delay and increase workload.

Additional pressures have been placed on the ASG operational and professional management, as there is a requirement to offer necessary support and mentoring to new staff and other ASG staff. This vacant ASG lead post also impacts on the current Governance arrangements to provide assurances that care is safe and effective which leaves the service vulnerable.

The lack of business support has impacted on the current workload of the ASG staff. Without having the appropriate business support the ASG staff have spent considerable time gathering data taking them away from undertaking their core roles and functions.

The deficit of ASG resource and the potential risks has been escalated and is currently on the Corporate Risk Register.

In order to address this increase in demand, which is only likely to increase, a proposal paper has been put forward for additional funding so that additional WTE DAPO staff are recruited.

An action plan has been developed to address the ASG backlog. The Service Manager with ASG responsibilities is currently undertaking the line manager role to provide support and mentorship to inexperienced ASG staff who are under pressure in the absence of the ASG Lead.

Weekly meeting ASG huddles are held with DAPOs by the Divisional SW and Service Manager to provide support to teams and assurance. This has impacted on the ability of the Service Manager and Divisional Social Worker to fully undertake other aspects of their roles.

There is a system in place to ensure that all referrals are allocated to DAPO's by the Operations Manager.

A Procedural manual has been developed by the Divisional Social Worker for LD to assist DAPOs in relation to completion of forms and documentation and adherence to the ASG process.

The Divisional Social Worker and Service Manager are also supporting the ASG staff in relation to PCC referrals through regular meetings.

Learning Disability continues to work very closely with the Training Department in the Trust who have been extremely flexible and responsive in terms of providing additional training for all staff in the hospital. This has included bespoke training for DAPO and IO staff, for medical staff, management and for contemporaneous CCTV viewers etc. This has ensured all staff are sufficiently trained and upskilled in relation to specific aspects of safeguarding.

3. Challenges in the provision of Safeguarding services that have arisen during the reporting period and actions taken to mitigate any difficulties.

COVID-19 Pandemic.

Although there was business as usual adherence to Regional Policy there was a need to change some of the local processes in light of the pandemic.

COVID ASG contingency plans were developed for the community and hospital.

There was a move from face to face to virtual weekly meetings, patients were seen using of PPE, CCTV viewed as quickly as possible when required. The use of virtual meetings and PPE has had implications when communicating with families, service users and staff. This resulted in investigations being more time consuming and at times, many of the nuances that one picks up from face to face meetings were lost.

A number of actions were taken because of COVID which included:

- updating all external providers with contact details, thresholds for ASG referrals;
- establishing an ASG Data base to identify priority cases; creating a central point for referrals through APGT;

- liaising with PSNI re Domestic Violence cases;
- sending alerts to RESWS;
- ensuring daily contact with high risk service users; and
- information was published on Trust Hub and Twitter regarding safe spaces, silent solution initiative etc.

A number of these initiatives worked very well however, the service areas did struggle, like other areas, because of a lack of IT equipment, access to a socially distanced office space and remote working.

The lack of structured activities due to the closure of day care, the lack of independent review of care homes/ community facilities and the concerns in relation to domestic violence were all challenges for the service area.

PARIS Information System.

The service area continues to use the ASG forms from the previous policy and await PARIS implementation to ensure staff move to using the new documentation. Additional PARIS training will also be required to train up DAPO/IO staff and referral agents when this is being introduced. A significant amount of documentation, flowcharts and aide memoires will also have to be amended to reflect the new documentation.

Safeguarding within Muckamore Abbey Hospital.

Over the reporting period there continued to be a significant number of Adult Safeguarding referrals in relation to both patient on patient incidents (136) and staff on patient incidents (85) within Muckamore Abbey hospital. The total number of referrals in the hospital was 221 and therefore lower than last year's referrals (241).

A low threshold is applied to all adult safeguarding referrals given the ongoing large-scale investigation following a high level of abuse identified from the viewing of CCTV in 2017.

Since 2017, there has been an increased level of scrutiny in the hospital and this resulted in an RQIA Improvement notice in relation to Adult Safeguarding, as outlined above. A significant number of improvements have taken place as outlined above. This has included the development of a large data set, which has been used to help understand and analyse trends and patterns to enhance patient safety.

During the reporting period, there has been 85 staff on patient incidents referred to the Adult Safeguarding Team.

A large number of staff on patient referrals relate to a small number of patients. A number of referrals are screened out very quickly after viewing CCTV, looking at witness statements etc. The majority of the screened out incidents relate to times when a service users mental state has been poor, or associated with a service user who has behaviours that challenge.

Within Muckamore Abbey Hospital CCTV is available in all the wards. The benefit of the CCTV is that ASG staff are able to screen cases on the basis of independent evidence of what did or did not happen. CCTV was not available for a significant number of incidents as

they may have occurred in a private area or the referral did not specify the date/time/location of the incident to enable CCTV viewing.

The viewing of CCTV can also be very time consuming especially if the exact time/ date of the alleged incident is not known and so the term 'screened out' does not mean that no work was involved.

The service area is pleased to report that the vast majority of staff on patient referrals were first raised by staff. This is a very significant cultural change, when you consider that during the period of CCTV historical abuse at Muckamore Abbey Hospital there were very few whistleblowing concerns raised by staff.

There is ongoing Contemporaneous CCTV viewing across the hospital site. Although the Contemporaneous CCTV viewing generated a small number of referrals, it demonstrates the important contribution of contemporaneous viewing of CCTV. It is providing an extra level of assurance. Areas of good practice and areas for development are identified and taken forward.

A number of themes have been established in relation to some of the staff on patient referrals and as a result a number of workshops are being convened in the hospital. This is to include additional training, enhance awareness of the patients care plans, enhance understanding of safeguarding, restrictive practice etc. Some work is also underway to review the induction which the nursing and health care support staff receive and the ongoing supervision arrangements. This is particularly important given the high number of agency staff used across the hospital site.

A bespoke training session was also arranged in relation to adult safeguarding for the senior management team in Muckamore by the Training and Development team. A further training session is being arranged in May 2021.

The ongoing historical and current investigations in relation to staff has had a significant impact on the stability of the hospital workforce and the welfare of staff given that a large number of both registrants and non-registrants have been placed on precautionary suspension and/or on supervised practice.

A number of carers and families remain stressed and distressed by the investigations and this has resulted in the need for families to be offered additional support and assurances.

In relation to Patient on Patient Referrals in Muckamore within the reporting period there were 136 patient on patient referrals. There has been a general reduction from previous years. This arose for a number of reasons- ward managers were trained to screen out low level referrals; 39 patients discharged from Jan 2019 (6 of which have been discharged in the last financial year); and there has been an increase in patients being nursed separately in individual pods across the site.

The majority of patient on patient ASG incidents across the site related to a small number of patients who have allegedly been harmed by other patient. A number of patients would not have the skills to protect themselves or to understand the risks.

Several measures have been taken to protect patients and to reduce the likelihood of other patients causing harm. This has included staggering meal times, changing the environment, increasing activities off the wards, increased observation levels, etc.

Despite a number of steps taken to protect patients and to reduce the risk of patients harming others it is not possible to eradicate ASG incidents. There are many interconnecting

factors, which still leads to incidents occurring in communal areas e.g. patient's mental health, communication difficulties, behaviours that challenge, the environment, the mix of patients and the staffing.

The Adult Safeguarding (ASG) team have continued to develop a robust database so that trends and patterns can be analysed. This data is presented at the monthly ASG Forum, which is attended by the MDT team and has been used to improve patient safety through more informed decision-making.

All ASG incidents are reviewed on a weekly basis at the Adult Safeguarding MDT meeting which the DAPO chairs. Risks are identified, analysed and protection plans reviewed in relation to new and existing ASG referrals.

The high level of public scrutiny, the pressures on the existing staff across the site, the increase in historic referrals and a deficit of adult safeguarding resource continues to present challenges.

Safeguarding within the Community.

There has been a decrease in the number of referrals received by the community ASG from 168 last year to 143 this year. It is highly likely this is related to the impact of COVID and the fact that the learning disability day centres and short break facilities were closed.

The community teams service has continued to investigate concerns raised in community settlings, including nursing homes, residential homes, supported living units day care etc.

The 143 community referrals cover a range of abuse including alleged physical abuse (72), sexual (9), neglect (16), psychological abuse (20), financial abuse (22), institutional practices (3) and exploitation (1).

Within community facilities, a number of referrals are because of group living. This brings with it issues in relation to the environment, quality issues and the mix of patients. Care plans are reviewed regularly; staff are upskilled and additional support provided in an attempt to reduce the likelihood of further incidents.

There have also been a number of large-scale complex investigations into alleged abuse in several community facilities, which has had an impact on the ASG workforce capacity.

Again, given the resources issues in ASG across LD a number of the community Team Leaders with DAPO responsibilities have also had to take on work from the hospital site relating to staff on patient incidents to ensure objectivity.

The community team recognise the importance of having more accurate data so that an analysis can be carried out to look at trends and patterns across the community. A robust data sheet has now been developed, similar to the one created in Muckamore, which will assist in the analysis of data, enhance preventative work and inform decision-making.

ASG work streams were established to take forward learning from the Community ASG audit, internal reviews, SAI's and a pending SAI level 3 investigation. A significant amount of work has flowed from this including, creation of aide memoires, a procedural manual etc. Additional training for community ASG staff has been facilitated in relation to interviewing staff, clarifying the roles of DAPOs and IOs and completion of ASG documentation. ASG huddles are now in place to enhance oversight and governance arrangements. Supervision and review arrangements are also being reviewed and a new ASG supervision tool as well

as ASG case audit tool has been developed and implemented. The staff continue to be encouraged to attend the DAPO, IO and ABE support groups facilitated by the ASG Learning and Development Trainer. The Trust ASG Lead is also facilitating a workshop with referral agents to enhance the quality of referrals and raise awareness.

Historical CCTV Adult Safeguarding investigation.

The Muckamore Abbey Hospital large-scale historical CCTV adult safeguarding investigation remains ongoing. This continues to be an extremely complex and time-consuming investigation.

From a safeguarding perspective, it is positive to note that at this stage all raw footage CCTV relating to the timeframe of the historical investigation has been viewed by either Trust or Police. MAH Historical ASG team have completed raw footage viewing of Cranfield 1 & 2 and Police have completed viewing of Six Mile assessment and treatment. Therefore, collectively all raw footage CCTV has been viewed by either Police or Trust. The plan going forward is that each agency (Police and Trust) will ultimately view all CCTV footage for the time frame of the investigation.

There are currently two core investigation processes ongoing – the Police led investigation and the Trust disciplinary investigation.

In this reporting period there have been a number of MAH staff arrested and questioned by Police in relation to MAH Historical Investigation. On Friday 16 April 2021, the Public Prosecution Service confirmed via media that they were progressing with criminal prosecutions in relation to seven MAH staff. This is a positive development in terms of the Police investigation and signals the next stage in the investigation process.

The Trust disciplinary investigations are ongoing and to date a small number of staff have been dismissed. The disciplinary investigation process is complex and it is anticipated that there will be a number of other staff who will be subject to disciplinary investigation.

The focus of the MAH Historical ASG team's work over the last year is as follows:

- View raw footage to identify incidents of concern.
- Making referrals to senior management via HR for interim protection plans and where appropriate making referrals to PSNI for Police investigation.
- The MAH Historical ASG team are also working on the second viewing of the PICU incidents forwarded to them by PSNI.
- Quality-assure the current database alongside the merging of other relevant information held in a separate database.
- The team are also engaged in ongoing family liaison work, with each affected family having a nominated family liaison social worker. Police also have family liaison

officers appointed and there has been ongoing positive joint working in terms of liaison with families regarding the reporting of incidents of concern.
- In addition, the MAH Historical ASG team hold cross-Trust meetings with Northern Trust and South Eastern Trust as some of the affected families have been from their localities.
- Provide information when requested by the external disciplinary investigators.

Further Updates in this reporting period include:-

- The software solution referenced in the last DSF report has been developed and is being utilised to complete CCTV viewing. This has been a welcome development as it has improved the CCTV viewing process.
- The 3-weekly Operational group meetings comprising of representatives from ASG team, HR, senior Nurse Advisor, RQIA and PSNI are ongoing and provide a forum for update and discussion on progress re the various work strands.
- A further development this year has been the establishment of a specific work-stream with a focus on interim protection plans. There are currently regular meetings taking place to facilitate a review of all current interim protection plans. These meetings involve MAH Adult Safeguarding, senior Nurse Advisor, RQIA and PSNI.
- The Health Minister, Robin Swann announced on 8 September 2020 his intention to call a Public Inquiry into allegations of abuse at Muckamore Abbey Hospital. He also said he would consult with families, patients and former patients on the terms and format of the Inquiry. He has now written to the families of patients to update them on the arrangements for hearing their views. He has asked the Patient and Client Council to facilitate this work on his behalf. The consultation with families commenced week of 7 December 2020.
- The announcement in relation to the Public Inquiry was welcomed by the Belfast Trust and the Trust have recently advertised a post in preparation for the Public Inquiry. To date we have received no confirmation of the terms of reference of the Public Inquiry.

ACOPS:

The Adult Protection Gateway Team (APGT) continues to operate a dual system consisting of duty function to screen and co-ordinate adult safeguarding referrals for the Division and an investigation function. APGT has operational responsibility for adult protection investigations for Older Peoples Programme of Care and Physical and Sensory Disability.

Within this reporting period OPS received 954 Adult Safeguarding referrals, of the total referrals received 46% of referrals were screened out, 22% of referrals met the threshold for an Adult Protection Investigations to be commenced and for 10% Alternative Safeguarding responses were implemented. 21% of referrals were transferred to community teams within OPS for an adult safeguarding investigation. This continues to represent a significant over reporting of inappropriate referrals and requires a significant investment of resource, in relation to the level of screening

required to manage referrals safely. In the forthcoming reporting period it is the intention of the service area to undertake an improvement project to better understand reporting behaviours and to identify ways to reduce inappropriate referrals, using Quality Improvement methodology.

The impact of the pandemic was particularly felt in the first quarter of the reporting period, and resulted in a significant drop in adult safeguarding referrals, as highlighted below. This was particularly noted in relation to referrals from the Care Home sector, where referrals over this reporting period, have reduced by 43% to the previous year.

However, conversely PSNI referrals increased significantly over the reporting period 2020/21, with an increase of 203% in referrals noted form the previous year. However, many of these were noted to be welfare referrals as a result of the pandemic as opposed to allegations of abuse.

In response to the emerging patterns as the pandemic progressed, Older People's Services put in a number of mitigations, which included:

- In the early months of the pandemic, the service area established weekly Adult Safeguarding huddles with all ACOPS service areas to monitor changing patterns in referrals, to ensure timely remedial action was taken and to seek assurances that sufficient staffing was available to respond to referrals

- Updated data sets have been established to support trends analysis for ACOPS referrals and facilities

- All Trust Care Home referrals were centralised through a single point and Care Homes were reminded through letter and fora that they must continue to report Adult Safeguarding incidents

- Trends/ analysis of Care Homes Adult Safeguarding referrals discussed at weekly commissioned services governance meeting

- MARAC structures were supported to be maintained within the Division during surges

- Social media messaging and podcast was developed for sharing across Trust platforms to raise awareness of Adult Safeguarding
- Specific areas were targeted to raise awareness of Adult Safeguarding, through focused communication strategies including the development of new awareness posters. These were areas that were likely to have contact with service users and families during lockdown. These included Emergency Departments, NIAS, GP's, Domiciliary Care and District Nursing.

- Adult Safeguarding training was targeted at staff who were being redeployed into new roles as a consequence of the pandemic

- Concerns in relation to referral patterns were added to the Divisional risk register and were escalated to the HSCB Regional AS Group

During this reporting period the Division has commenced an improvement project, to assure the full implementation of Adult Safeguarding arrangements across the Division, considering arrangements not just within Social Work services but also across all areas where care is delivered. This considers key factors including: training of staff, awareness of reporting procedures, systems for analysing referral patterns, ensuring discussion of adult safeguarding at live governance, safety huddles and briefings, and quality assuring information held in all teams. This has been an extensive piece of work with a baseline audit conducted across 12 service areas. The outcome of this audit will form the basis of a Divisional Improvement Plan, which will include the establishment of a Divisional Adult Safeguarding Governance Group. To support the Division in this work we have appointed in March 2021, a new Adult Safeguarding Service Manager, who will not only manage the Adult Protection Gateway Team, but will also take forward a number of key improvement areas.

Another improvement focus is the undertaking of an audit of adult safeguarding responses and investigations, for adults who are at risk of harm, but are not in need of protection. It remains a risk across the Division that there are no regional standards for the management and investigation of adults at risk of harm. In the continued absence of this, the Division is commissioning a piece of work to support standardisation and consistency, through the development of local guidance.

Adult Safeguarding in Hospitals has had an acute focus for the Division in this reporting period. Within both Valencia and Meadowlands, RQIA identified concerns in relation to staff's ability to recognise and analyse adult safeguarding issues and trends. This led to 2 significant pieces of work in relation to the training and development of staff and the development of systems across both wards, to raise awareness of adult safeguarding and to capture activity. Whilst staff responded well to the improvement, it did highlight deficits within other professions in relation to their awareness of adult safeguarding issues, which is similar across the wider hospital system. The Adult Safeguarding Champion for the Trust is currently leading on a piece of work to develop additional training resources and action plan, to support hospital based staff to discharge fully their responsibilities in relation to safeguarding vulnerable patients. Furthermore, Hospital Social Work continues to work closely with other hospital professionals in promoting children and adults safeguarding awareness. Hospital Social Work is currently developing a communication and engagement strategy with hospital wards to promote domestic violence and safeguarding awareness.

Within this reporting period, the service area have noted increased delays with PSNI investigations, and the PSNI have advised that this is as a consequence of the impact of the pandemic. However, this has an impact on service user's confidence in the process as well as causing additional distress.

PHSD:

With regards to Adult Safeguarding, there continues to be an ongoing challenge in balancing the service user's right to a private life and promoting his/her individual choice to make their own decisions which may place them at risk of abuse. During this reporting period, the level of reporting, after an initial drop off during the first lockdown, has remained relatively stable in comparison to the previous year.

The 3 top types of abuse referred to the service area for investigation are physical, financial and psychological, with the predominant setting from which referrals arise. is the service users own home.

The service area partook in a number of ACOPS initiatives that were developed to redress the impact of the first lockdown including a social media campaign and targeting of specific areas for increased awareness.

The service area continues to have strong links with the Belfast Area Domestic & Sexual Violence and Abuse Partnership and there continues to be a focus on Adult Safeguarding awareness raising amongst our disabled population and the groups who work with them.

The service area also acknowledges the fact that a pressurised caring role can at times result in Adult Safeguarding concerns, and therefore staff have continued to identify carer stress and offer carers support, during this difficult time for carers.

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Mental Health:

During the reporting period Mental Health has continued to provide an ongoing service within COVID restrictions. As lockdown and social distancing -measures decrease, staff have increased face to face contact with mental health service users in provision of adult safeguarding investigations. Mental Health initially noted a decrease in adult safeguarding referrals from care homes, however measures were put in place with increased contact with care homes by Mental Health staff and Care Management maintained weekly contact completing a questionnaire with care homes where adult safeguarding was monitored as part of this process.

The Mental Health Adult Safeguarding Team are in the process of completion of an Adult Safeguarding audit across the service area for governance and quality improvement. This now will be a bi-annual audit. Currently within the Mental Health service area, one of the areas for improvement is in the use of the Adult Safeguarding thresholds for safeguarding investigation as defined within the Adult Safeguarding Policy of an Adult at Risk of harm or an Adult in need of protection. This is not currently being used consistently across the service area and impacts on data collection for stats where there is no differentiation in the type of adult safeguarding investigation undertaken on the data return.

The Mental Health Adult Safeguarding Lead delivered an information session to all staff completing data collection returns including DAPO's and Line Managers in an effort to improve returns in this area. Also covered in this session was definitions of screening out a referral and alternative safeguarding response which also causes unreliable data reporting. For the purposes of DSF reporting, all of the monthly data

returns were reviewed with community teams and have been amended to appropriately reflect thresholds and responses and are being forwarded to HSCB. While the Mental Health service is in the process of PARIS implementation, where reports can be sourced for relevant data, it is hoped that this will improve data collection returns for mental Health in the interim.

Following an RQIA inspection in Shannon Clinic MSU December 2020, concern was expressed regarding Adult Safeguarding practice within Shannon Clinic. This was in respect of staff knowledge of recognising and reporting adult safeguarding, delays in adult safeguarding referrals being screened by Line Manager, IO/DAPO role, cross referencing of incidents and adult safeguarding referrals, quality of protection plans and adult safeguarding data not being reviewed to analyse trends for learning and service improvement. A quality improvement action plan was instigated to ensure staff training in Adult Safeguarding is completed as per mandatory requirements, incidents are reviewed to ensure safeguarding referrals are completed, all meetings have adult safeguarding as a standing agenda item, weekly audit of the PARIS duty desk to ensure that safeguarding referrals are dealt with in a timely manner by Line Manager and forwarded to DAPO as appropriate.

An Adult Safeguarding notice board is in place on each ward with an adult safeguarding flowchart and aide memoire of an adult safeguarding referral to assist staff and ensure they are aware of the reporting procedure. An Adult Safeguarding tracking document has been developed to record all incidents for analysis, trends, learning and service improvements where learning is shared. Regular governance meetings are in place where adult safeguarding issues are discussed including Bed Management meetings, live governance meetings, safety briefs, DAPO/ASM meetings where Datix incidents and Adult Safeguarding are reviewed and that appropriate incidents are considered under the Adult Safeguarding Policy and Procedures.

The DAPO in Shannon Clinic completes monthly reviews of Adult Safeguarding referrals to ensure quality and for improvement. In addition, Adult Safeguarding Lead Nurses have been identified for the three wards in Shannon Clinic who will undertake IO training, and Ward/Deputy Ward Managers have undertaken Level 3 Line Manager training. An audit was also undertaken of Adult Safeguarding referrals and protection plans by the Mental Health Adult Safeguarding Team with feedback provided for improvement and learning.

Training of IO/DAPO's was initially stood down during COVID-19 lockdown, however all IO/DAPO training and support groups are being offered via Microsoft teams to increase numbers of IO and DAPO staff across Mental Health. Currently there are adequate numbers of IO and DAPO within core community teams with some teams such as Addictions service area increasing numbers of nursing IO trained staff. Deficits remain within Therapy teams for DAPO trained staff and some Band 7 Therapists who

are Social Work trained have declined to undertake the training or the role. This issue has been escalated to the Service Managers for the service area to highlight the need for appropriate numbers of DAPO staff within their service area.

The Mental Health Adult Safeguarding Team continue to provide DAPO cover to teams in the community that have no Band 7 DAPO. All service areas continue to be encouraged to consider internal workforce planning to ensure appropriate numbers of IO trained Band 6 and Band 7 DAPO trained Social Work staff to fulfil the adult safeguarding role.

The Mental Health Adult Safeguarding team are currently completing an audit of all bandings of staff within teams to ensure compliance to relevant adult safeguarding training and refresher training as per mandatory requirements for their role.

The Mental Health Adult Safeguarding Team is currently in the process of implementing PARIS for adult safeguarding referrals to the team, and for adult safeguarding investigations where a DAPO is within the Mental Health Adult Safeguarding team. The Social Work team in Shannon Clinic are also using PARIS for all adult safeguarding referrals and IO investigations. All other teams within Mental Health await PARIS implementation for Adult Safeguarding. This will also require additional virtual training, a process document for the service area and development of a training video for IO/DAPO and admin staff in the use of the adult safeguarding documentation, alerts, management of the duty desk and inputting of Adult Safeguarding referrals.

The Mental Health Adult Safeguarding Team are meeting with the PARIS implementation team with other service areas in the development and implementation of the APP documentation on PARIS which is scheduled to be in use for Protection investigations by June 2021. The new APP investigation documentation will deal with Adult in need of Protection adult safeguarding investigations. Risk of harm investigations are not considered within the new APP documentation and will require consideration for how these investigations will be completed. This is important for the Mental Health service area as the majority of safeguarding investigations completed are within the Risk of harm threshold and a full adult safeguarding investigation is completed.

Joint Protocol investigations and the numbers of PIA interviews and ABE interviews continue to decrease within Mental Health due to police thresholds for Adult Safeguarding investigations. As a result, only one member of staff was put forward for ABE training in January 2021. New DAPO staff have been trained in Joint Protocol for referring adult safeguarding cases and consultations with CRU. Band 7 Social Work staff have been prioritised currently for PIA training due to limited available places for face to face training due to COVID. Band 6 staff will be considered as per the needs of their community team and service area as we move forward from current social distancing measures.

SECTION 4: Activity Returns.

Chart1:

Belfast Health and Social Care Trust received 3174 Adult Safegaurding referrals from April 2020 to March 2021. This was an increase of 568 referrals compared to the previous reporting period.

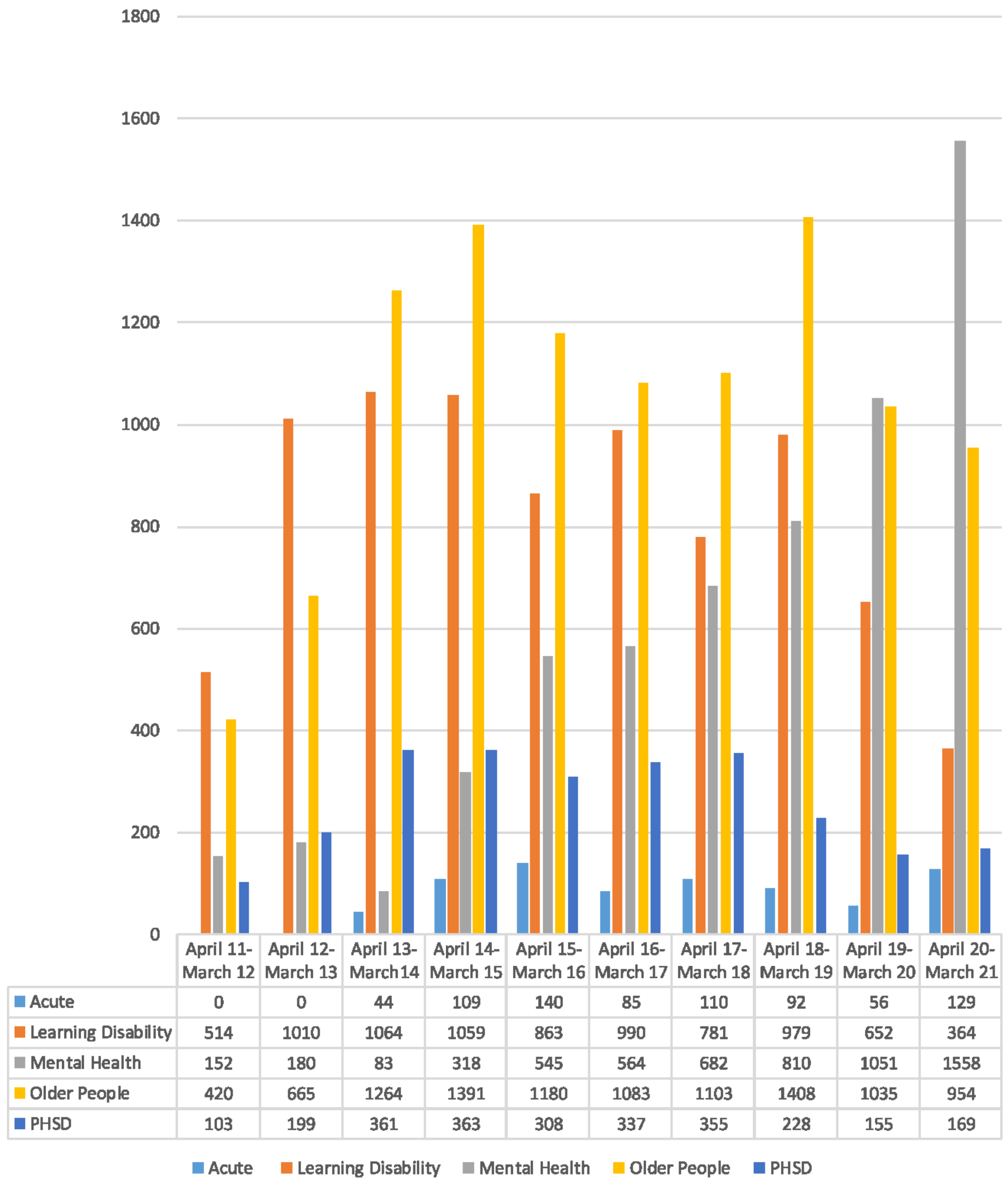
Mental Health received the highest number of referrals in 2020/21 with 1558 recorded. Equally, Mental Health recorded the highest number of referrals screened out; 1032, mental health Adult Safeguarding screened out activity accounts for 66% of referral activity over this reporting period. Mental Health commenced 503 Adult Safeguarding/ Adult At risk of harm investigations and 7 adult in need of protection investigations. Mental health Adult Safeguarding hit a 10 year peak in recorded Adult Safeguarding activity with a 48% increase in referrals from the previous reporting year.

Older Peoples Service received the second highest number of referrals with 954 recorded. Older Peoples screened out 46% of referrals, with 208 Adult Safegaurding/Adult At risk of harm investigations commencing and 206 adult in need of protection investigations commencing. However, Older Peoples service has recorded a gradual decline in referrals over the past three reporting years, with a peak in 2018/19 of 1408 referrals and gradual reduction over the two following years.

Physical Health and Sensory Disability Referrals remain much lower in comparison of the other service areas with 169 referrals received and 44% of referrals screened out. PHSD experienced a slight increase in referrals with 14 more compared to the previous report period. In 2020/21 PHSD commenced 39 Adult At risk of harm investigations and 36 Adult in need of Protection investigations.

Learning Disability Services received 364 Adult Safeguarding referrals this year, with 138 referrals screened out. Learning Disability commenced 190 Adult at risk of Harm investigations and 67 Adult in need of protection investigations. Learning Disability recorded a decline of 44% in referrals this reporting year compared to 2019/20.

Chart 1:



	April 11-March 12	April 12-March 13	April 13-March14	April 14-March 15	April 15-March 16	April 16-March 17	April 17-March 18	April 18-March 19	April 19-March 20	April 20-March 21
Acute	0	0	44	109	140	85	110	92	56	129
Learning Disability	514	1010	1064	1059	863	990	781	979	652	364
Mental Health	152	180	83	318	545	564	682	810	1051	1558
Older People	420	665	1264	1391	1180	1083	1103	1408	1035	954
PHSD	103	199	361	363	308	337	355	228	155	169

Chart 2:

Table Of Adult Safeguarding Activity Years2017- 2018, 2018-2019, 2019-2020 & 2020-21																				
	Investigations				Protection Plans				Joint Protocol				PIAs				ABE Interviews			
Years	17/18	18/19	19/ 20	20/21	17/18	18/19	19/20	20/21	17/18	18/19	19/20	20/21	17/18	18/19	19/20	20/21	17/18	18/19	19/20	20/21
Acute Sector	6	10	11	9	4	10	9	21	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disability	352	591	232	157	343	553	150	300	34	180	10	25	0	2	4	3	1	0	0	2
Mental Health	364	420	554	560	362	411	352	473	21	10	9	4	12	10	2	4	9	3	0	4
Older People	448	601	663	414	444	579	554	211	58	73	27	32	24	42	21	15	12	11	5	1
PSD	131	101	89	75	129	99	70	39	14	21	4	3	10	11	1	5	2	4	1	3

Chart 2 outlines the Adult Safeguarding activity over a four year period.

Investigations:

The reporting period 2020/21 noted a decline in adult safeguarding investigations commenced across all programmes of care with the exception of mental health whereby this service had an additional 4 investigations commenced compared to 2019/20.

Older People Service recorded a significant reduction in investigations commenced in 2020/21. This is a reduction of 37% compared to the previous reporting period.

Protection Plans:

The recording of protection plan activity remains an area to target. Data for this reporting period indicates there is an issue with recording an interpretation of the HSCB Data requirement. The data presented in chart 2 suggests there is a disparity in investigations commenced and protection plans implemented.

Joint Protocol:

Chart 2 and Chart 3 outline the joint protocol activity for the reporting period 2020/21 and an enable a comparison to be drawn. Over the reporting period 2020-2021, the BHSCT Adult Safeguarding staff completed 417 Joint Protocol Consultations with PSNI. This is a 9% increase compared to the previous reporting period 2019/20, whereby 380 joint protocol consultations took place.

Similarly, the number of joint protocol investigations commenced in 2020/21 increased by 24% with 64 joint protocol investigations commenced, compared to 50 joint protocol investigation commenced the previous year in 2019/20.

The number of Pre Interview Assessments completed over this reporting period was 27, one less than the previous year where 28 PIAs took place in 2019/20. The data obtained relating to the Achieving Best Evidence interviews (ABE's) remains relatively low, with 10 ABE's completed within this reporting period, four more compared to 2019/20.

Chart 3:

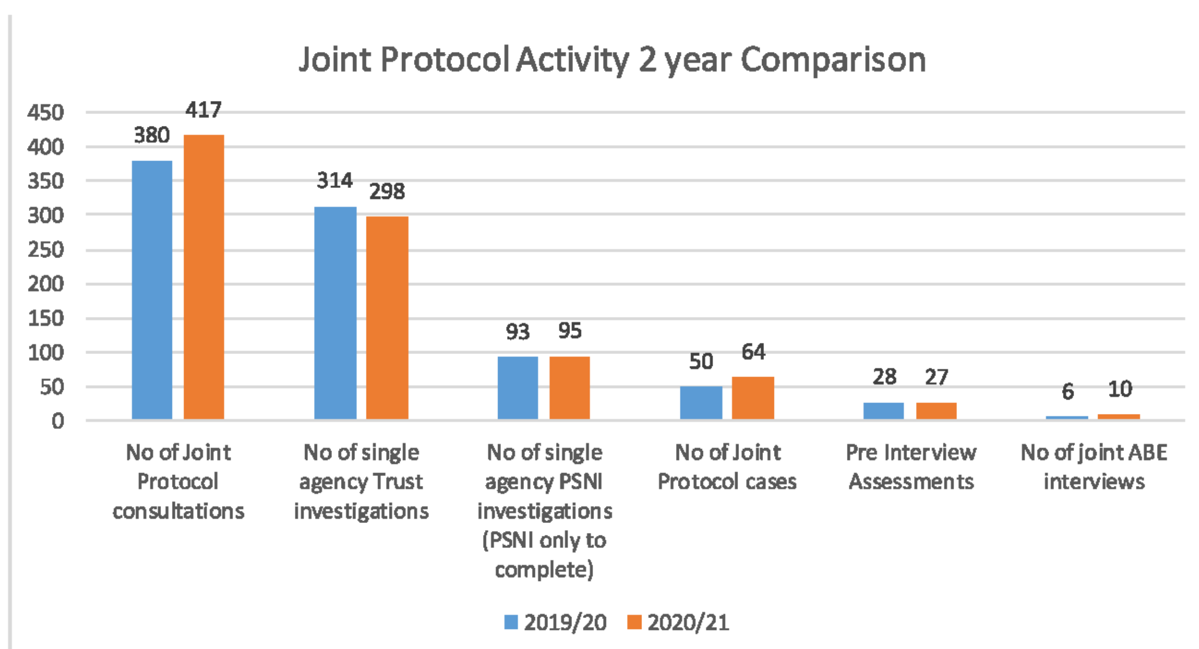


Chart 4:

Source of Referral for the reporting period April 2020- March 2020 outline the sources of Adult Safeguarding referrals received by the Belfast Health and Social Care Trust. Self referral was the highest recorded source of referral with 1140 self referrals made to BHSCT Adult Safeguarding. This is a 50% increase compared to the previous reporting year.

Referrals increase by 86% in 2020/21, however the relative figure remains low at 95 referrals from carers on 2020/21 compared to 51 in 2019/20.

In 2020/21 referrals from PSNI increased by 195% with 204 reported to Adult Safegaurding.

Referrals from regulated care homes decreased by 42% in 2020/21.

Chart 4:

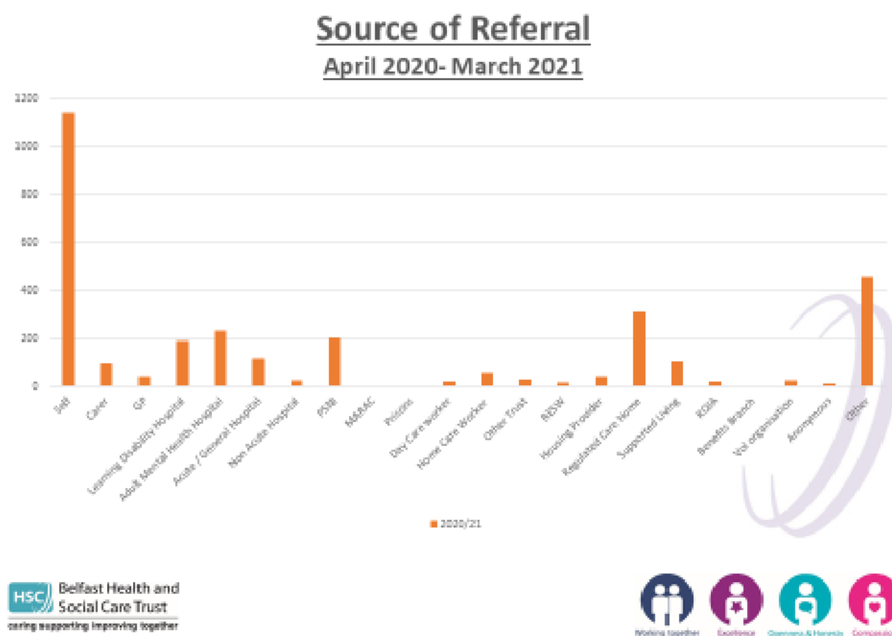


Chart 5 & Chart 6:

Chart 5 provides a breakdown of category of abuse for the reporting period 2020/21. Chart 6 provides a breakdown of category of abuse by programme of care.

Belfast Health and Social Care Trust Adult Safeguarding referrals recorded 44% of referrals relating to Physical Abuse. This is a comparative figure to the previous reporting period whereby Physical abuse was the highest recorded category of abuse. Physical abuse was the highest recorded category of abuse across all service areas.

Mental health noted a significant increase in referrals relating to physical abuse. In 2021, mental health recorded 605 physical abuse incidents, compared to 368 the previous reporting period, this is an increase of 64%.

Sexual abuse accounts for 23% of referrals for the reporting period 2020/21. Mental Health had the highest number of sexual abuse referrals with 587 referrals relating to Sexual abuse in 2020/21. This is an increase of 44% compared to 407 the previous reporting period.

Financial abuse accounts for 11% of Adult Safeguarding referrals received. Older Peoples service had the highest number of financial abuse cases compared to other programmes of care with 136 incidents of financial abuse. However, older people services recorded a 27% reduction of financial abuse incidents reported to Adult Safeguarding compared to the previous reporting period.

Chart 5:

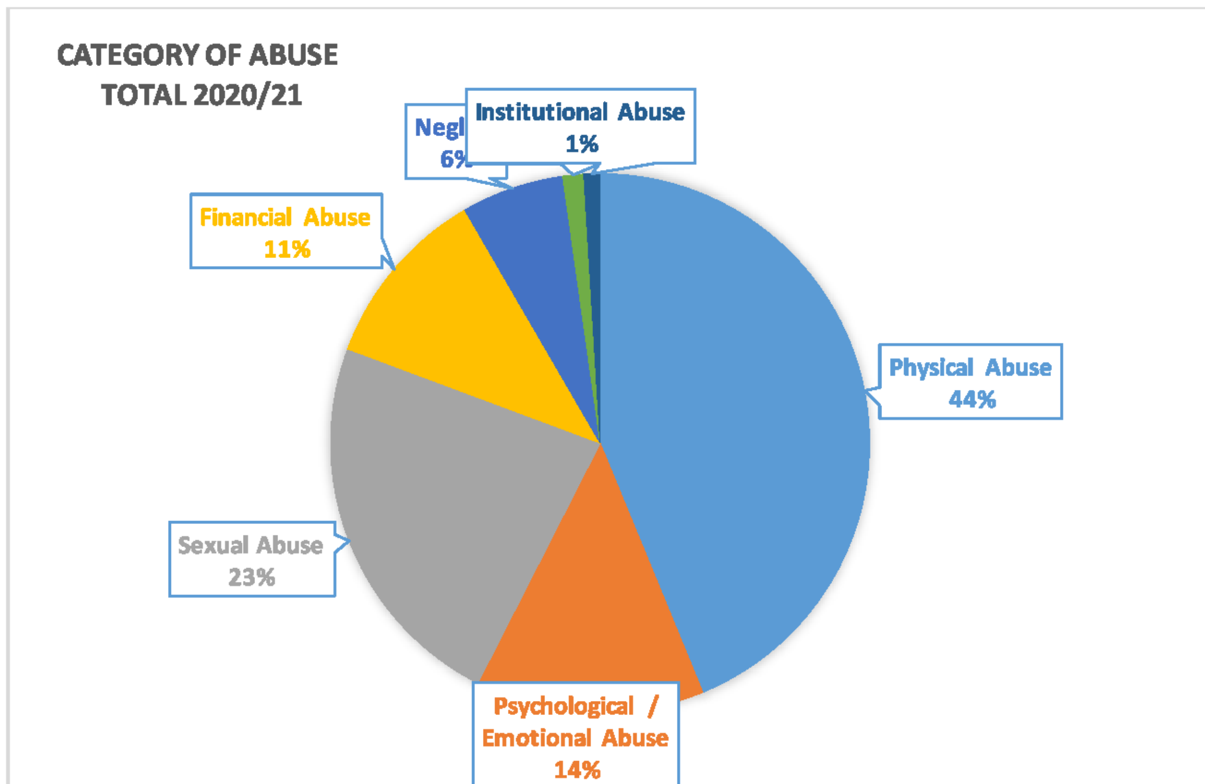
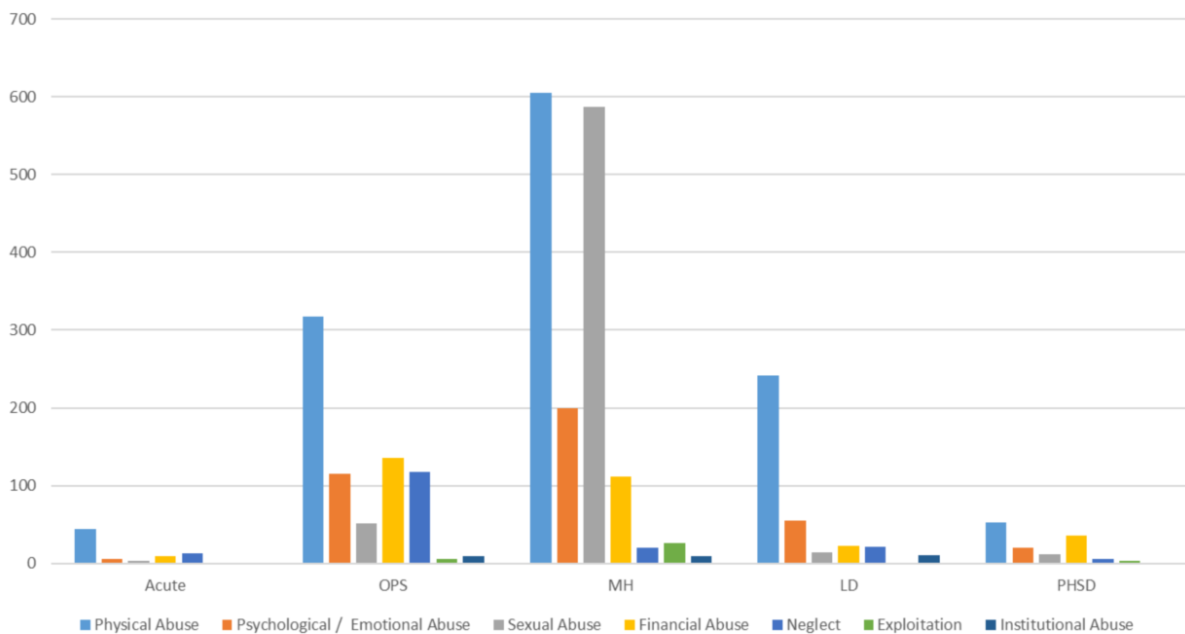


Chart 6:



SECTION 5: Trust Adult Safeguarding Action Plan 2020-21 (summary)

Action:	Update
Review of current Adult Safeguarding Structure	Ongoing
Adult Safeguarding Training - SCOPE Trust wide training needs	Completed Scoping exercise completed and paper written with Learning and Development manager and Strategic Adult Safegaurding Team
Adult Safeguarding Workforce	Completed Review of current workforce Centralised data base operational
Development and implementation of APP suite of forms onto Paris Module. Encompass and Adult Safeguarding Future Development	Ongoing Work recommenced A new project management group established
Adult Safeguarding Data Collation and Analysis	Achieved Current baseline established, reviewed data collation and, retrieval & analysis in line with HCB data returns
Review current delivery of adult safeguarding Policy & Procedures	Ongoing Strategic Adult Safegaurding review of current processes
Service User Engagement	Outstanding
Interface between Adult Safeguarding and other Trust processes	Ongoing Focus on Adult Safeguarding and HR processes
Joint Protocol	Outstanding To be carried forward in line with regional work streams
Adult Safeguarding in Hospital Settings	Ongoing Task and Finish Group established Power APP for Acute Hospitals
Ensure current partnership working arrangements are maintained and strengthened	Ongoing LASP continues to take place 4 times a year
Adult Safeguarding Champion Forum	Achieved Group Established

Review and strengthen Trust wide Adult Safeguarding Governance arrangements	Ongoing Paper submitted to Adult Safeguarding Committee
Review current arrangements for current Adult Safeguarding Shared Learning and ensure there is a robust system in place for shared learning	Ongoing
Implementation of the recommendations from COPNI	Ongoing
Implementation of the CPEA recommendations	Ongoing
Adult Safeguarding Champion Position Reports	Ongoing