Belfast Health and Social Care Trust

caring supporting improving together

Belfast Local Adult Safeguarding Partnership (LASP)

Annual Report 2018/2019

CONTENTS

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 Local Adult Safeguarding Partnerships (LASPs) are located within each of the Health and Social Care Trust areas. The role of LASPs is to implement Northern Ireland Adult Safeguarding Partnership (NIASP) guidance, policy and procedures at a local level. Membership is drawn from local statutory, voluntary, independent and community sectors, including representation from Criminal Justice Agencies, Local Commissioning Groups, Local Authorities and the Faith Community.

The annual LASP work plan is reviewed under the three core themes contained in Adult Safeguarding Prevention and Protection in Partnership (2015).

The report includes an update from each Trust service area in relation to adult safeguarding, with each service area detailing challenges, achievements and activity levels.

LASP partner organisations are also provided with an opportunity to detail adult safeguarding work undertaken within their organisation during the reporting year.

SECTION 2: Work plan for Reporting Period
Achievements and Challenges

PROTECTION

Adult Safeguarding Structures within the Belfast Trust

Currently within the Belfast Trust each service area have their own separate arrangements in place for delivery of adult safeguarding. While these service area arrangements have been effectively delivering on adult safeguarding work for a number of years, it had been agreed that the current structures would be amended to reflect the requirements of the Prevention and Protection in Partnership Policy 2015. The Department of Health (DOH) Policy details the structures required within Trusts in terms of a single Adult Protection Gateway Service.

The Trust took the decision to develop a single Adult Protection Gateway Service and remains committed to delivering on this objective. This work has been delayed due to other operational priorities but the Trust remain committed to developing a Trust wide Adult Protection Gateway Service.

Work in relation to the development of this new Adult Protection Gateway Service will be progressed by the Trust Adult Safeguarding Specialist (TASS) and the three divisional social workers for each service area.

Adult at Risk of Harm work

The Trust recognise the importance of ensuring that there are robust arrangements in place in response to adults at risk of harm when the threshold for an adult protection investigation has not been met. The need for professional risk assessment/risk management strategies and alternative safeguarding responses is recognised as pivotal to the safety and welfare of this group of service users. There is also a need to ensure that effective governance and monitoring arrangements are in place for adults at risk of harm. As detailed in the Older Peoples Core team service area report, work is currently underway to develop the necessary tools to ensure that this important area of work is appropriately and effectively addressed.

Role of the Adult Safeguarding Champion (ASC)

The Belfast Trust ASC is accountable to the Executive Director of Social Work for the discharge of their role. Given the size of the Trust, the ASC role has been delegated down through the current reporting structures, with first line managers being responsible for the operational delivery of the role. Within social work, many of these line managers are already trained DAPOs and are therefore very familiar with the ASC role and where this fits within the wider adult safeguarding structures and reporting arrangements.

Adult safeguarding training for line managers has been amended to ensure staff are fully briefed on the ASC role and responsibilities. There is a need for widespread training of

line managers to ensure that they are fully briefed on their role as ASCs but given limited resources this is currently being managed on a phased basis. In the interim any adult safeguarding referrals received by a DAPO not meeting the threshold for an adult protection investigation will result in advice being given regarding the need for a professional assessment and alternative safeguarding response.

RQIA inspection in Hospital Outpatient Departments across the region

An RQIA inspection of Outpatient Departments in hospital settings identified a lack of knowledge among staff (medical and nursing) in relation to adult and child safeguarding. The Belfast Trust drafted an action plan in response to issues identified. This action plan included a number of actions. Of particular note are proposals to develop a new Adult Safeguarding Nurse Specialist post similar to the current Specialist Nurse Child Protection posts. It is anticipated that this will help ensure adult safeguarding is embedded in the acute sector. Job descriptions are currently being drafted

Regional Joint Protocol

The primary aim of the regional Joint Protocol 2016 is to ensure that adults at risk of harm who have experienced harm which constitutes a criminal offence have equal access to the justice system. The Protocol further seeks to promote a rights based approach in relation to the individual's views and wishes. In this reporting period Trust adult safeguarding staff continue to view as positive the limited discretion within the Protocol which facilitates a sensitive and proportionate response. Trust staff have, however, also continued to report instances when there are differences between PSNI and Trust in relation to the interpretation and scope of the Protocol. The Protocol includes a process of escalation where there is a difference of opinion between Trust and PSNI and this has been used appropriately and effectively.

A review of the Joint protocol is ongoing and practice issues identified are being addressed within the review process. The working group taking forward this review includes representatives from Trusts and PSNI. RQIA, as co-signatories to the Joint Protocol, have also provided an input into this review. The review had been put on temporary hold at PSNI's request and was further delayed as a result of the Belfast TASS sick leave. The working group have reconvened and held a two-day workshop in Garnerville. It is hoped that a first draft of the revised Joint Protocol will be available for consultation in June/July 2019.

Scamwise

Scamwise Northern Ireland Partnership have produced the fourth edition of the 'Little Book of Big Scams' and have shared these books with Trusts for onward circulation. The Trust welcomes the opportunity to assist with this very significant area of financial abuse.

PSNI are also in their second year of a rolling programme to raise awareness of financial abuse and in particular scams. Year one focused on training Trust domiciliary care workers in order to heighten their awareness of potential scams, so that they could assist vulnerable service users in early identification and scam avoidance. Now in year two the

Trust are working with relevant PSNI scam prevention officers to facilitate training of independent sector domiciliary care staff. Feedback from Trust staff in year one was very positive and it is anticipated that this success will be mirrored in year two.

COPNI Report and Independent Review commissioned by Department of Health

The COPNI report Home Truths and the issues of concern highlighted within this report have formed the basis of an action plan at regional and local Belfast Trust level. Belfast Trust have participated fully in regional meetings to discuss and address issues raised and have also been looking at Trust practice at a local level.

The Trust have welcomed the independent review commissioned by DOH and have met with the Independent Review Panel to discuss its role in relation to Dunmurry Manor.

More recently DOH notified each Trust to submit an anonymised list of all adult safeguarding referrals commenced in nursing homes during the period 01.03.17.-28.02.19. They subsequently clarified that this list should include nursing, residential and supported living. Trusts were advised that CPEA would be conducting an audit in relation to 50 files which would be randomly selected from the list submitted. Belfast Trust have submitted lists as per DOH requirement and await clarification on files submitted for audit. In addition, on 12 March 2019 the CPEA independent review team held a working session for social work practitioners involved in adult safeguarding cases in Dunmurry Manor Nursing Home. Each Trust was asked to nominate 8 practitioner staff to attend this event. Belfast Trust practitioners in attendance at this session reported that it provided a useful opportunity to reflect on practice and consider areas for improvement.

The current culture is one of openness, reflection and learning and the Belfast Trust have embraced opportunities to reflect on current practice.

Belfast Trust Learning and Reflection Workshop

The Trust Adult Safeguarding Champion organised a Belfast Trust adult safeguarding workshop with a focus on reflection and learning. [redacted] facilitated this workshop, which was well attended by adult safeguarding staff across all programmes of care. Members of the Trust collective leadership teams also attended, as did senior consultants and senior nurse colleagues. [redacted] shared with the group the themes and issues that had emerged from her extensive portfolio of conducting high-profile reviews such as Winterbourne View and Operation Jasmine. The themes and initial learning from her review in relation to Muckamore Abbey Hospital were also discussed and she touched on some of the initial learning from the COPNI and DOH independent review in relation to Dunmurry Manor. The workshop was very interactive and allowed for a reflective discussion on adult safeguarding experience and practice within the Belfast Trust. The work from this session will inform Belfast Trust adult safeguarding practice going forward.

Pressure Ulcers within an Adult Safeguarding Context

HSCB and PHA gave a commitment to develop a regional Safeguarding Adults Protocol in relation to the interface between pressure ulcers and adult safeguarding. A regional working group was established and the Belfast TASS contributed to this by convening a

regional meeting to look specifically at the threshold/criteria for referral of pressure ulcers into an adult protection process. Specifically the group were tasked with looking at the Department of Health (DOH) England 'Safeguarding Adults Protocol - Pressure Ulcers and the Interface with a Safeguarding Enquiry' (January 2018), to consider whether this would meet the needs in a Northern Ireland context. This group drafted initial views and this work helped inform a regional workshop on 10th October 2018. HSCB and PHA have since drafted a guidance document in relation to the management of pressure ulcers and this is currently out for consultation.

The Belfast Trust Adult Protection Gateway Team have previously made referrals to police under Article 121 of the Mental Health Act in relation to potential wilful neglect. As noted in the APGT service area report, the Public Prosecution Service have taken the decision in [redacted] to refer to PHA. The Belfast Trust welcomes plans to reach a regionally agreed position in terms of the interface between adult safeguarding and pressure ulcers.

Capacity Assessments

In April 2019 the Trust received confirmation from the Royal College of Psychiatrists NI that a decision had been taken that Financial Capacity Assessments would not form part of core NHS work for Consultant Psychiatrists. The view taken was that financial capacity assessments can often be complex, requiring the obtaining and assimilation of much information in addition to detailed clinical assessments. The decision to deem a Patient incapable of managing their financial affairs can have far reaching consequences. In addition, there may be a perceived conflict of interest in cases where the Trust has asked for a Financial Capacity Assessment and a Psychiatrist is acting as an officer of that Trust.

The consensus view from the Royal College of Psychiatrists is that Financial Capacity Assessments are not part of core NHS work for Consultant Psychiatrists; rather they are special medico legal or category 2 work. As such, our opinion is that Consultant Psychiatrists are not obliged to carry out this work as part of their job plans. The only exception to this is when a Patient is detained as an inpatient under the Mental Health (NI) Order 1986, when a Consultant acting as RMO may carry out a Financial Capacity Assessment if necessary as part of that Patient's care. There may be other exceptional clinical circumstances when a Consultant may conduct a Financial Capacity Assessment in cases of immediate clinical need.

Trusts were advised of the need to make alternative provisions for these assessments. This will have significant implications for the Trust and for Adult Safeguarding in terms of financial abuse allegations. While the number of Trust assessments privately funded is currently quite low, it is anticipated as a result of this notification there will be a need for the Trust and Adult Safeguarding to be clear regarding arrangements in place going forward.

The issue of capacity to consent to and/or contribute to a police investigation is an important element of Adult Protection work and Joint Protocol. To date the Trust have provided these assessments when required and occasionally have needed to fund these privately. Police are of the view that Trusts are best placed to provide these assessments. In light of the Royal College of Psychiatrists' position in relation to financial capacity assessments, there will be a need to clarify their position in relation to capacity assessments for Joint Protocol.

Complex Investigations

Central to the work of Adult Protection is the management and co-ordination of complex investigations, many of which relate to large scale investigations in regulated services. These investigation are resource and time intensive and are managed within the context of competing priorities. The multi-agency nature of many of these large scale investigations, along with issues associated with working across Trust boundaries, can be challenging. For the agencies who have staff subject to investigation, protection plans can also be resource intensive. As detailed in the Learning Disability service area report, the Muckamore Abbey Hospital adult protection investigation is ongoing. The work involved in this investigation is critical to the safety and welfare of the patients and is a key priority for the Belfast Trust.

Adult Safeguarding / Adult Protection Funding

The Trust welcomes the additional funding provided in relation to adult safeguarding work.

The non-recurrent funding of £39,400 was utilised to help fund the Muckamore Abbey Hospital adult protection investigation. It is important to note that this investigation is very time and resource intensive. Funding of this investigation and any subsequent investigations of this scale will require ring-fenced funding from DOH.

The recurrent funding of £112,000 is also welcomed and the Trust are currently considering how best to utilise this additional funding. There are competing priorities for this funding, as each service area could benefit from additional DAPOs to support their work in complex adult protection investigations.

The Trust had in previous reports highlighted the need for additional funding in relation to adult safeguarding training and delivery of adult safeguarding training continues to be a challenge for the Trust.

Data Returns

The Belfast Trust continue to collate HSCB monthly data returns manually and as in previous years this has proved challenging. Priority is understandably given to casework and this has resulted in collation of information being a secondary consideration. The Trust continue to struggle to ensure accuracy in collation of information and to avoid duplication in terms of statistical returns. The new HSCB reporting template was implemented in October 2018 and is currently subject to regional review. It continues to be the aim of Belfast Trust to ensure that the new Adult Safeguarding Module on Paris will provide the necessary statistical collation. Work in relation to this is ongoing.

PARTNERSHIP

Belfast LASP

The Belfast LASP normally meet quarterly but due to TASS extended sick leave, only three meetings were held within this reporting period. Attendance at LASP meetings has fluctuated this year, in part due to changes in named LASP representatives for partner organisations.

The LASP work plan for 2018-19 has also been impacted by TASS sick leave and TASS operational pressures associated with work in Muckamore and back-fill in the Adult Protection Gateway Team. There is a need to re-energise Belfast LASP in terms of membership, focus and an achievable work plan for 2019-20, which is inclusive of the aims and objectives set by NIASP and by LASP members.

Policing & Community Safety Partnership (PCSP)

The TASS continues to represent adult safeguarding on the South Belfast PCSP. Adult safeguarding continues to be an established area of work in terms of the PCSP Action Plan. There is currently a project in South Belfast - Growing Older Growing Safer, which aims to increase the safety of older people in South Belfast with access to prevention, early intervention and protection. The project supports community guardians who will provide support and information to organisations and individuals with regard to keeping themselves safe.

On 7 March 2019 the PCSP held a community event for seniors in the Finaghy Road area of Belfast. A local councillor and the Lord Mayor were in attendance. This event included a number of information stalls, one of which was a Trust-manned stall providing information on adult safeguarding, local Trust services and self-directed support. The event was well-attended and feedback received on the day was positive.

NIASP

The TASS continues to represent Belfast Trust at a regional level on NIASP. TASS attendance at NIASP facilitates the sharing of information from NIASP to LASP. LASP members view this as a key positive as it ensures they are kept updated on regional issues and regional developments.

Human Trafficking

In November 2018 Trusts were issued with an updated version of the Working Arrangements for the Welfare and Protection of Adult Victims and Potential Victims of Human Trafficking & Modern Slavery. This guidance document was jointly issued by DOJ, Police and HSCB and had been developed in discussion with DOH. As the NIASP representative on the DOJ Engagement Group, the Belfast TASS has been working with the Modern Slavery Strategic Training & Data Coordinator in the Protection & Organised Crime Division / Modern Slavery & Human Trafficking Unit, to look at raising awareness

of the guidance document and the role of Trusts. An initial information session has taken place with the regional TASSs and work is planned with the regional training group. It is anticipated that bespoke training for key staff will be devised. The conduit for taking forward this work is that it will fall within the remit of adult safeguarding. The Belfast TASS and the South Eastern Trust TASS are currently working on a proposal in relation to a Trust internal referral pathway.

Domestic & Sexual Violence and Abuse Partnership / MARAC

Trust Adult Safeguarding are represented on the Belfast Area Domestic & Sexual Violence & Abuse Partnership by the TASS. Attendance at meetings has been problematic due to sick leave and competing operational priorities. That said, there is relevant communication with the Chair of the Partnership. The TASS had chaired the MARAC work-stream but this had been put on hold following changes at regional level, which included the MARAC Operational Group being disbanded. It is understood that a new strategic MARAC Operational Board has been established with Terms of Reference and objectives set. The Belfast MARAC will reconvene to ensure delivery of regionally agreed objectives.

Domestic Violence & Abuse Disclosure Scheme

The Domestic Violence & Abuse Disclosure Scheme, launched in March 2018, continues to function following MARAC meetings. Issues around information sharing and the decision making forum continue to present challenges.

PREVENTION

Adult Safeguarding Training

The BHSCT delivers the 5 levels of Adult Safeguarding training as outlined in the NIASP Training Strategy and Framework (revised 2016). These 5 levels are designed to equip staff of different bands develop the knowledge and skills commensurate with their job role and experience to support adults in need of protection and to promote staff confidence and competence in effectively carrying out their adult safeguarding role. The Training Strategy is compatible with the Adult Safeguarding Policy 2015, Regional Operational Procedures, 2016 and the Joint Protocol, and all training materials are designed to raise standards, promote best practice and ensure consistent and proportionate responses to safeguarding issues. Training is provided for all levels and our specialist Investigating Officer/Designated Adult Protection Officer and Joint Protocol Trained staff are supported through quarterly support group workshops.

This year the Learning & Development service has continued to deliver to social work and social care staff and due to the high level of demand from other programmes of care, we reserve a number of places for any Belfast Trust employee whose primary role is work with adults. There continues to be requests from many different service areas and we have delivered some bespoke training to try to meet these demands. Lifeline staff became Belfast Trust employees and they received bespoke level 1 adult safeguarding training. Other examples include Estate services and Palliative Care staff. However, there remains concern that we continually have to turn down requests and in this last year, in particular from medical staff including staff from the GUM clinic, Geriatric services, psychiatry, nursing and OT services. While they access a limited number of places on the awareness raising courses concern remains that they do not appear to have access to Adult safeguarding training for the numbers required. This in turn highlights the potential that the implementation of the Regional Operational Procedures and Joint Protocol is not standardised across these different service areas.

There continues to be a high demand for Level 1 Adult Safeguarding awareness raising and mandatory refresher courses. The RQIA requirement for the social care workforce to attend Awareness Raising training is the primary driver supporting compliance. The requests for bespoke training for these service areas is considerable. The Learning & Development team continue to respond to requests for bespoke training. For example, this year we delivered bespoke awareness raising training to new staff in the Mental Health Assessment teams and a 2 day bespoke training for both investigating officers and designated adult protection officers within the mental health POC. A further example was 2 sessions in Muckamore Abbey regarding quality recording in the Adult Protection referral forms.

Several programmes of care are continuing to undergo reorganisation and it is anticipated that these programmes of care will require additional training to develop confidence and competence in relation to screening referrals at ASC/Line management level and in relation to quality recording in all APP forms. This will have an impact on resources within the training team.

Action 2019 – 2020:

- To ensure that all training material is contemporary and compatible with 2015 and 2016 Policy & Procedures to ensure staff are knowledgeable about roles and responsibilities in adherence to regional requirements.

- To continue to support staff through the quarterly facilitation of practice support groups for staff undertaking the roles of IO, DAPO and Achieving Best Evidence interviews. This ensures that staff are cognisant of the current NIASP strategy and that issues from a staff perspective are understood. It also involves inviting speakers and sharing relevant adult safeguarding research to ensure staff are aware of up-to-date developments related to adult safeguarding.

- To continue to sustain and develop effective relationships with PSNI and Regional Adult Safeguarding trainers in the delivery of the NIASP training strategy.

- Continue to be committed to meet workforce needs in working towards full implementation of the regional policy and procedures. It has been emphasized that these documents are 'live' documents' and therefore it is imperative that staff are kept updated in relation to on-going changes.

- To deliver bespoke training to reorganized POC's to ensure confidence / competence in relation to screening and thresholds that are compliant with the 2016 Regional Policy and that recording of required forms are of a high quality.

LASP Prevention Group

The focus of the LASP prevention group continues to be compatible with the NIASP strategic plan 2013 -2018. The group meets on a quarterly basis and membership of is derived from voluntary and statutory sectors. The group continues to increase awareness of adult safeguarding to communities through the well-established projects that have been developed and sustained.

A review of the Keeping You Safe project was completed in July 2018 and the outcome was that while large numbers received the training the number of active staff delivering the training was low due to a variety of reasons including staff moving to new posts, retiring or leaving the trust. Existing staff attended an update session in July and this was well received and achieved the aim of ensuing that Adult Safeguarding messages are standardized and consistent with current policy. The programme was evaluated positively and is viewed as a very useful resource for service users. This will continue to be delivered across a range of regulated facilities and in all service groups. There continues to be an additional session for new staff who want to deliver this training and this was likewise well attended and evaluated. This is a very important project as it is designed to empower service users to recognize abuse and know who to talk to if concerned. It is imperative that the current staff trained to deliver this programme to service users are supported and encouraged to continue to remain involved. It is equally important that new staff are recruited on a yearly basis to ensure that key adult safeguarding messages are far reaching and that service users are involved as co-facilitators.

Towards the end of the last year the group considered developing a DVD to assist in the delivery of adult safeguarding messages but subsequently decided against this project as a more regional one was being developed and there was a risk of duplication. This may be revisited, as the thought process was a DVD to be shown to service users as opposed to staff.

The group continues to meet on a quarterly basis and will focus on organizing workshops for ASC's in commissioned services who are now required to complete a yearly return position report. The aim of these workshops will be to establish the level of confidence in relation to completing these forms and will assess understanding of commissioned services understanding of the position report, what are the expectations and what support will they require going forward.

Adult Safeguarding Training Activity	No. of candidates attended	No. of courses held during the reporting period
ABE 5 Day	16	1
ABE 7 Day	2	1
ABE Practice Support Group	24	3
ABE Refresher	8	3
Adult Safeguarding Level 1 Awareness	424	20
Adult Safeguarding Level 1 Refresher	671	43
Adult Safeguarding Level 2	52	3
Adult Safeguarding Level 3 Investigating & Designated Officers	61	3
Adult Safeguarding Level 4 Joint Protocol	24	1
Chairing Skills for Designated Officers	22	3
Court Skills (IO/DAPO)	14	1
Designated Officers Practice Support Group	49	4
Investigating Officers Practice Support Group	181	4
Keeping You Safe for Facilitators	31	2
Keeping You Safe Review	12	1
LASP Prevention Group	26	4
MARAC	29	2

Period – 1st April 2018 – 31st March 2019

SECTION 3: Belfast Trust Adult Safeguarding Activity Returns

Chart 1: Belfast Trust Safeguarding Referral Rates April 2011 - March 2019

Chart 2: Belfast Trust Monthly Safeguarding Referral Rates by Service Area April 2018 – March 2019

Chart 3: Belfast Trust breakdown of Adult Safeguarding Activity by Service Area

Chart 4: Table of Percentage Increase / Decrease in Adult Safeguarding Activity

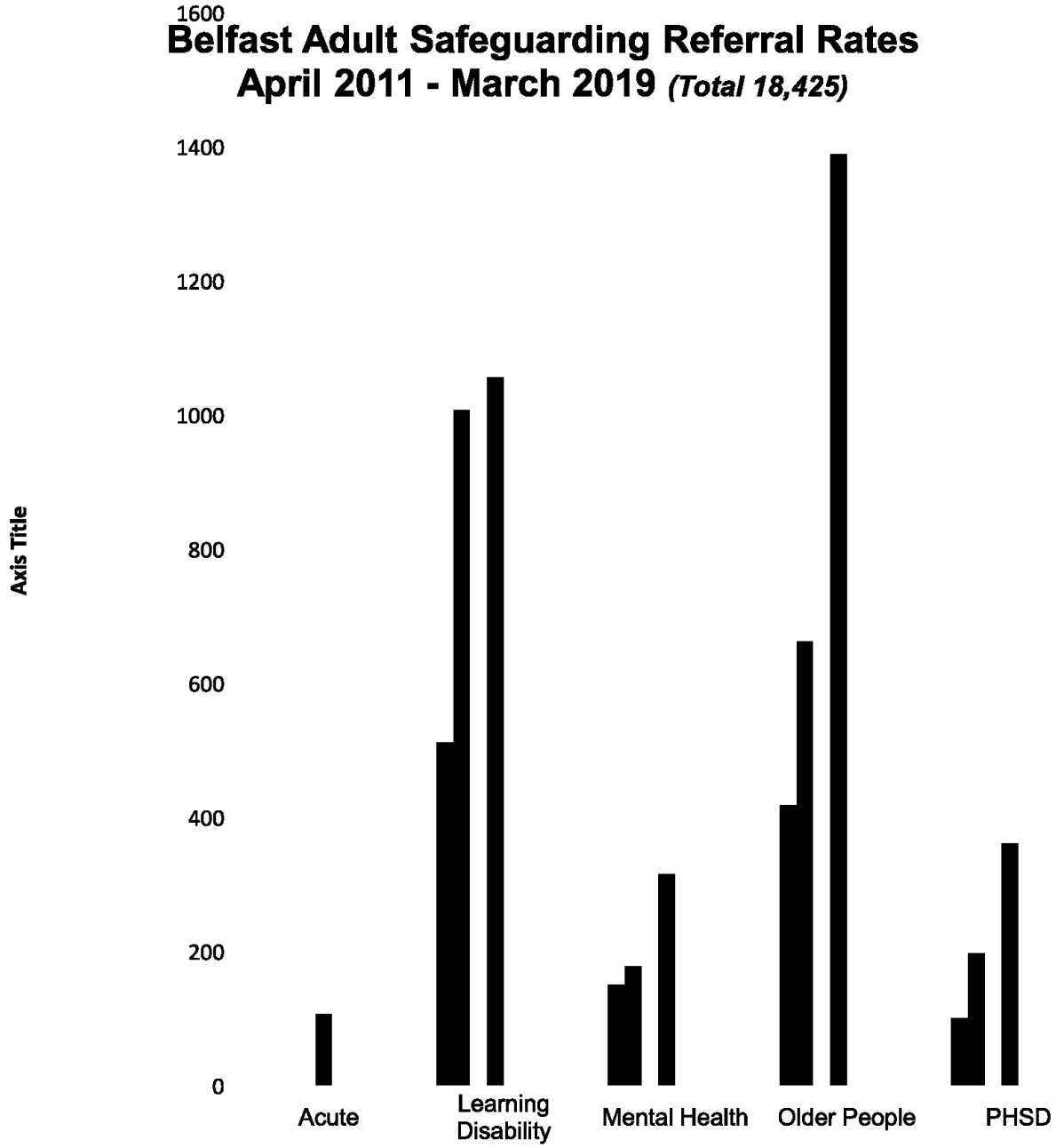
Data Returns

Analysis of data returns is included in each service area report. This section therefore focuses on the overall position in relation to the Belfast Trust statistical returns.

As detailed earlier in the report, the Belfast Trust continue to find the current system of manual collation challenging. The Trust are working with Paris developers to set up a system where in future this information can be collated directly from Paris.

In this reporting period April 2018 to March 2019 the Belfast Trust received a total of 3,517 referrals. 1,723 of these referrals resulted in an adult protection investigation. There is clearly significant work to be done to ensure more accurate reporting of adult protection cases. This will be a key piece of work for Belfast Trust in the coming year.

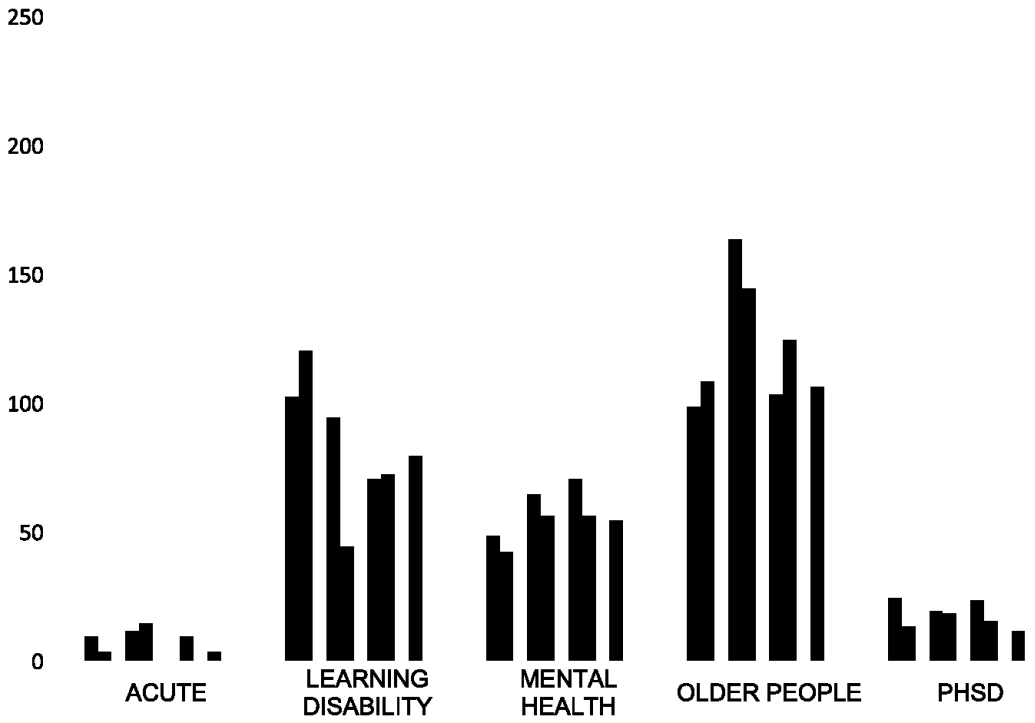
CHART 1



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

Referral rates have continued to rise year on year.

Adult Safeguarding Referral Rate by Month
April 2018- March 2019

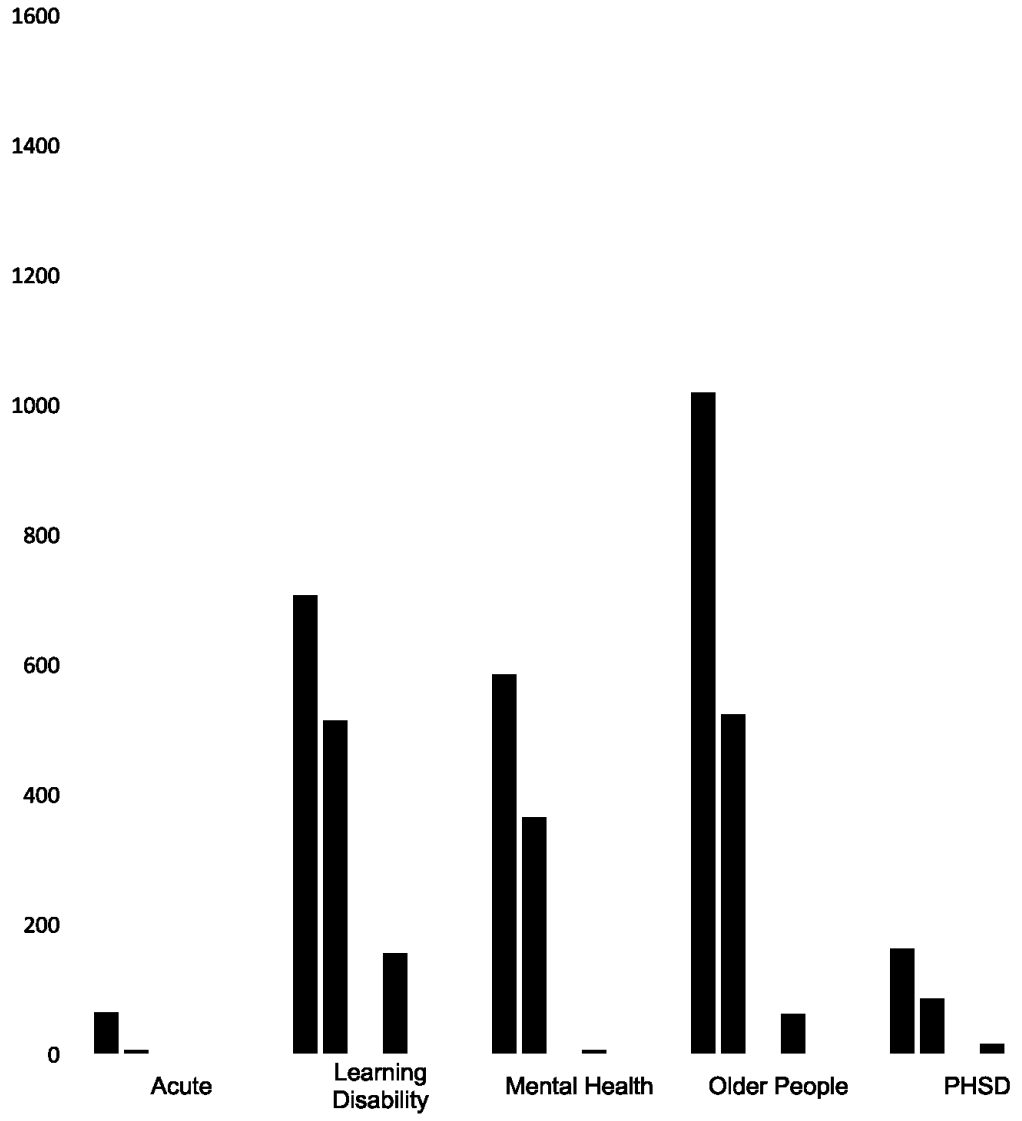


	ACUTE	LEARNING DISABILITY	MENTAL HEALTH	OLDER PEOPLE	PHSD
April	10	103	49	99	25
May	4	121	43	109	14
June	5	129	64	150	21
July	12	95	65	164	20
August	15	45	57	145	19
September	11	48	46	107	32
October	0	71	71	104	24
November	10	73	57	125	16
December	13	72	49	80	17
January	4	80	55	107	12
February	6	78	31	92	9
March	2	64	223	126	19

Note: astronomical data point for MH, March 2019 is due to non-reporting of data by specific teams during the year, then reporting in a cumulative manner for March 2019. Unable to separate into individual months.

CHART 3

Breakdown of Adult Safeguarding Activity by Service Area April 2018 - March 2019



	Acute	Learning Disability	Mental Health	Older People	PHSD
■ Referral	92	979	810	1408	228
■ Investigations	10	591	420	601	101
Protection Plans	10	553	411	579	99
■ Joint Protocol	0	180	10	73	21
PIAs	0	2	10	42	11
ABEs	0	0	3	11	4

The differential between referrals and investigations across each of the service areas highlights that, in real terms, the numbers of adult protection investigations is significantly less than would first be perceived, e.g. Older People 1408 referrals, only 610 resulted in an adult protection investigation, meaning that less than 50% resulted in an adult protection investigation.

CHART 4

Table Of Percentage Increase/Decrease In Adult Safeguarding Activity Years 17/18 to 18/19

Service Area	**Referrals**		**Investigations**		**Protection Plans**		**Joint Protocol**		**PIAs**		**ABE Interviews**	
Years	17/18	18/19	17/18	18/19	17/18	18/19	17/18	18/19	17/18	18/19	17/18	18/19
Acute Sector	110	92	6	10	4	10	0	0	0	0	0	0
Learning Disability	781	979	352	591	343	553	34	180	0	2	1	0
Mental Health	682	810	364	420	362	411	21	10	12	10	9	3
Older People	1103	1408	448	601	444	579	58	73	24	42	12	11
PSD	355	228	131	101	129	99	14	21	10	11	2	4

SECTION 4: Service Area Reports

PHYSICAL & SENSORY DISABILITY

Within the reporting period there have been 144 Adult Safeguarding referrals. 26% of this activity was assessed as not appropriate for the safeguarding frameworks. 43% were assessed and considered as level three activity and were subsequently managed by the Adult Protection Gateway Team with protection plans being implemented by that team. The remaining 31% were subject to investigation and protection planning from within the service area.

There has been a continued appropriate reporting of quality concerns with 33 referrals within the reporting period. This reflects the pattern in the previous reporting period and would suggest that professional staff continue to correctly utilise alternative safeguarding response processes.

All relevant staff in the community teams are trained to Designated Adult Protection Officer or Investigative Officer level. The updated Adult Safeguarding Operational Procedures were implemented in the service area in June 2017 and the Belfast Trust Training Team provided additional training to all relevant staff. Staff have continued to embed the Operational Procedures into practice.

The implementation of the Operational Procedures and the Designated Adult Protection Officer role has been positive within the service area. The Designated Adult Protection Officers in the service area make decisions upon the thresholds for all referrals and are responsible for activity relevant to situations involving adults at risk of harm, including the consideration of alternate safeguarding responses and the investigation of adult safeguarding concerns. Therefore, there are no referrals/consultation with the Adult Protection Gateway Team in relation to those adults as defined within the Operational Procedures as being 'at risk of harm'. The service area continues to find the transition positive for service users; it has reduced delay in decision-making, by eliminating the transfer of cases to the Adult Protection Gateway Team to await their decision-making and has improved service user experience by ensuring that the core team staff maintain involvement without interruption. However administrative demands continue, the service area has a limited number of minute takers and discussions continue regarding how this pressure can be relieved.

Across the reporting period, interface challenges with the Adult Protection Gateway Team remain. This primarily relates to consistency and clarity in decision making within referrals involving suspected criminal activity, wherein the Protocol for Joint Investigation is required; and cases being accepted for investigation involving 'adults in need of protection'. It is apparent that challenges remain regarding differences in operational understanding of this Protocol between the Belfast Trust and the PSNI. Such instances have caused delay, and it has been necessary for a small number of cases to be re-referred to the Adult Protection Gateway Team for further strategic discussion with colleagues in PSNI. The service area includes a number of trained Achieving Best Evidence interviewers; however, there are insufficient opportunities to embed this learning in practice and to meet NIASP requirements, given the lack of demand. This reduction on the demands of specially trained practitioners has been consistent with a rise in decision making within Joint Protocol strategy discussions between the Adult Protection Gateway

Team and PSNI which have resulted in single agency, PSNI only Achieving Best Evidence interviews. Staff within Physical & Sensory Disability service area continue to advocate on the behalf of those service users who may benefit in achieving equity to justice from the support available via 'special measures'. Additionally the levels of complexity of these cases being returned to core teams for investigation is very significant in terms of implementation of safety plans and responses to any emerging concerns.

With regard to user engagement within the safeguarding process, it is critical that we continue to ensure and demonstrate that individuals are fully involved in the interventions that bring about their desired outcomes. The 10,000 Voices project has provided a vehicle for important discussions and critical reflection upon the investigative process. The service area has continued to promote and encourage user participation within the survey.

The service area continues to utilise internal networks in terms of practice development. Furthermore, staff participate in the designated and investigating officer forums facilitated by the Training Team. Staff report positively on these opportunities.

The core teams continue to employ the community information system to record all activity. Unfortunately, the Regional Operational Procedures documentation is not yet available on PARIS, and availability of the updated administrative tools to record the investigative process will be welcome.

Throughout this reporting period the service area continues to foster a climate within which the implementation of the Adult Safeguarding Prevention and Protection Regional Policy (2015) and attendant regional procedures and joint protocol occurs. It continues to be essential that service users are equipped with the knowledge regarding what constitutes abuse and know the basic care standards. The Keeping You Safe programme is a priority for the service area and continues to be delivered to groups and individual service users by trained staff. This will enable and empower service users to assess risk, ensure quality and thwart detrimental behaviours developing. This labour intensive activity will increase demand upon the workforce but it is critical in assuring the prevention of harm. The Keeping You Safe programme recognises service users as experts in their own lives and provides the means to achieve contact with the right professionals if they so require it. It is vital in the effort to work preventatively regarding adult abuse and is a key objective for the service area. Work to continue the provision of this service user training programme is planned within the Day Centre forum.

ADULT PROTECTION GATEWAY TEAM

The Adult Protection Gateway Team (APGT), is now in its sixth 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. In the APGT this two tier function acts to provide a central point of contact for external referrals, for all internal safeguarding referrals for OP and for protection referrals forwarded by PSD. 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: 1 B8A Assistance Service Manager, 4 B7 DAPOs, 6 B6 IOs and 1 B6 Nurse Specialist. During this reporting period the rate of referrals, screened out, protection investigations and joint protocol investigations were as follows:-

	Older People Service		**Physical Health & Sensory Disability Service**	
	2017/2018	**2018/2019**	**2017/2018**	**2018/2019**
Total Referrals received	1103	1408	355	228
Total Level 3 Adult Protection Investigations	190	323	48	58
Total Screened Out referrals	351	429	135	84
Total Joint Protocol Investigations	58	73	14	21

Looking at a comparison from 2017/18 to 2018/19 there is an evident increase in Adult Protection L3 investigations and an increase in Joint Protocol Investigations over this period.

The task of screening referrals on duty continues to require a daily resource of one DAPO and one IO to manage. As noted above, the number of referrals forwarded to APGT continues to remain high in comparison to investigation figures. The level 3 adult protection investigations account for approximately 23% of the total number of referrals received by the APGT. However, the task of receiving and recording information, conducting screening processes and allocating referrals requires one quarter of the B7 resource within the team.

As reflected in previous reporting years, there remains a high number of inappropriate referrals sent to APGT for screening. Over the period of 2018/2019, approximately 32% of referrals were screened out of the adult safeguarding process. The APGT continue to receive a high number of inappropriate referrals from Care Homes and external agencies which include resident on resident incidents, quality issues, explained injuries, medication

errors etc. APGT have also noted a continuing trend whereby Care Homes report incidents to the Belfast Trust keyworkers, however they are then redirected to APGT to make a referral under Adult Safeguarding Policy and Procedures. This creates duplication for care homes who have referred the incident to RESWS or Community Teams/CReST and then directed to contact APGT, when on occasions many referrals are inappropriate and do not meet the Safeguarding Threshold.

Last year's report envisaged the requirement to work with Care homes to focus on thresholds for reporting adult safeguarding concerns. This action will be carried forward with the intention over the next few months to work with Care Homes which will focus on ensuring that the thresholds for reporting concerns are being applied appropriately and that the reporting pathways are clear.

This action is timely, as the statistical breakdown for OPS over the period of 2018/2019 reflected a significant increase in referrals to APGT for screening for Older Peoples Programme of Care. The statistics highlight a significant increase of 28% in referrals made to APGT for screening. The increase in referrals is most evident over the months of June 2018-August 2018 with referrals peaking at 164 in July 2018. The increase in referrals over this period can be linked to the release of the COPNI report mid-June 2018 which seen an increase in Adult Safeguarding referrals referred to APGT by Care Homes and external agencies.

Within the Belfast Trust there has been a phased approach to implementing the regional Safeguarding Policy & Procedures, with Older People service area being the last to be implemented. Significant organisational change and workforce challenges have resulted in delays in full implementation. Now that the CReST service is established it is anticipated that work with Care Homes and CReST will be carried out concurrently to ensure that there is further clarity regarding thresholds, reporting arrangements and referral pathways.

PSD implemented the new Procedures in June 2017. The ability for core services to screen their own referrals and to forward only protection referrals to APGT has been welcome and demonstrates a more appropriate use of the APGT gateway function. As both service areas are working within different safeguarding frameworks, APGT's ability to straddle two processes and pathways has been challenging. It is expected that current pressures will be alleviated when service areas are working within the same framework.

Followed on from the previous year, the Director of Adult Services determined that the Belfast Trust would move to one Trust wide Adult Protection Gateway service. This will require one team to act as a single point of contact and manage all adult protection cases. Given the current arrangements within the Trust, it is anticipated that Mental Health and Learning Disability services will join with the existing APGT. There has been some initial work in relation to the structure, function, role and remit of the new Trust wide protection team but further discussion and consideration of the remit of the team is required.

In addition to the gateway function, it is proposed that the APGT will also act as a central point of contact for all Human Trafficking, Female Genital Mutilation, Forced Marriage, No Recourse to Public Funds, Domestic Abuse and MARAC referrals. Within the framework of the new Trust-wide team the APGT will continue to hold responsibility for these areas

of practice, additional to this the development of audit and governance arrangements for both APGT and Core services will also be required.

The development of a Trust-wide team will require Core services to provide a screening and safeguarding response for those referrals that do not require a protection response.

Casework that requires a joint protocol, multi-professional or institutional investigation continues to be challenging, resource driven and time consuming. This is evident when regulated facilities particularly Nursing Homes are involved. The referral rates relating to abuse, exploitation and neglect in regulated facilities have remained consistently high with figures outlined highlighting a significant increase from the previous year. With the implementation of the new Policy and Procedures it has become evident that at times there has been a level of ambiguity in relation to the interpretation of cross Trust arrangements and the roles and responsibilities of host and placing Trusts. At times there also appears to be some variation in the role, function and remit of the Strategic Management Group across Trusts. This has been flagged with the NIASP Protection work-stream who are currently reviewing the Procedures. It is anticipated that the update of the regional Procedures will address the practice issues identified. In the interim, the Trust continues to work in partnership with other Trusts to ensure the safety and well-being of residents. This includes ensuring that investigations and protection plans are in place. In moving forward, further clarification regarding what is defined as an institutional investigation would also be helpful.

Over the reporting period of 2018/19 referrals and adult protection investigations vastly increased resulting in additional pressure on the staff within APGT. As a result, APGT were placed on the Risk Register in relation to an identified back log of case closure and recordings which fell outside the expected standards. This was subject to close monitoring and review by management of APGT.

In the last quarter of this period, APGT were subject to significant staffing changes with three senior members of the team, two DAPOS and the ASM/Team Manager, leaving the team to pursue temporary Expression of Interest Posts within the Trust. Additionally, APGT experienced the departure of Investigating Officers who left the team or moved into senior positions. The staff situation experienced by APGT has had a consequential impact on the team, APGT were placed on the Risk Register due to the staff shortages, however the void in the staff team remains ongoing despite actions from Senior Management to recruit and stabilise the service.

APGT were successful in recruiting B7 Social Workers/DAPOs, and partially successful in recruiting two B6 social workers, however the recruitment process is ongoing, with the pressing need to fill the empty posts. Due to the nature of the service delivered and the impact of recent staff changes within the team, APGT are now functioning with an inexperienced staff team, which requires enhanced monitoring and support from senior management for the foreseeable future.

Despite the practical challenges identified, APGT continue to function as the central point of contact for external agencies and continue to screen adult safeguarding referrals for OPS and investigate level 3 Adult Protection investigations for PSD and OPS. Additional challenges faced by APGT over this reporting period include APGT experiencing an increase in information requests from professional bodies such as NISCC & NMC. This is in addition to Freedom of Information (FOI) requests, subject access requests and Data

Protection requests from external managers, relatives and staff members subject to investigation. APGT continue to liaise with Data Protection and DLS when required to meet the requests outlined.

This has also highlighted the interface issues between Adult Protection Investigations and HR/Management Internal Investigations and the challenge faced when agencies attempt to use safeguarding reports as evidence during internal investigations. Responding to such information requests within specified timeframes places additional pressures on the team, this was evident over the past 12 months when APGT received numerous statistical data requests following the release of the COPNI report in June 2018. The collation of data and producing of reports exceeded the current staffing resource and created significant pressures within the team.

Over this reporting period, APGT experienced an increase in referrals from for OPS resulting in an increase in level 3 adult protection investigation in care home settings. The impact on the team resulted in an increase number of complex investigations with multiple incidents of abuse subject to investigation at any one time. As a result, the b6 specialist nurse was subject to a change in case work allocation and activity, such as removal from duty and allocation of specialist case work due to the increased volume of investigations and activity within Care Home settings. The specialist nurse role continues to remain a vital component within APGT due to the complexity of care home and nursing/ care related investigations referred into the Trust. A fundamental service provided by the nurse specialist is the facilitation of bespoke education sessions with care homes, service providers and agencies in relation to the Role of APGT and function of Adult Protection investigations within the Belfast Health and Social Care Trust.

There has been an increase in the requests and demand for the education sessions by agencies in an attempt to increase the awareness within care settings in relation to Adult Protection and Adult Safeguarding. Additionally, the specialist nurse attends and contributes to the review of regional strategic developments for example the development of the NIPEC guidance on safeguarding training in the nursing profession, developments relating to investigating pressure damage and chairing of quarterly Regional NIPEC meetings attended by specialist nurses across the region.

Due to the expert clinical area of work undertaken by the specialist nurse in complex investigations which include Article 121 of the Mental Health Order, Pressure Damage and Institutional Abuse, APGT senior management have conducted a review of the skill mix within the team and has proposed the appointment of a temporary B7 Specialist Nurse within the APGT. There is the intention to pilot this post for a 6 month period and review it in relation to role, responsibility and outcomes.

It continues to be the case that none of the Joint Protocol investigations conducted by APGT with police under Article 121 of the Mental Health Order have reached the threshold for prosecution as determined by the Public Prosecution Service (PPS). What is of note is that investigation processes in this area of work are elongated and protracted with outcomes for the most part of no prosecution. It would be beneficial and informative if the PPS could provide a clearer understanding of what constitutes a criminal threshold for wilful neglect and provide guidance around investigations and threshold for referral to police. Currently it would appear that police are seeking advice from PPS about thresholds for prosecution before investigations are concluded. While this is welcomed, it would be preferable if PPS and police could agree thresholds for wilful neglect. The

review of the Joint Protocol will consider in detail the use of Article 121. Following the regional review of pressure damage investigations, APGT conducted an investigation under Adult safeguarding and Joint protocol policy and procedures with a recommendation by the PPS for prosecution under Health and Safety Legislation, this is the first of its kind in the Belfast Trust area, with the process and outcome eagerly anticipated.

The number of investigations agreed as Joint Protocol by police increased by 26% for OPS and 50% for PSD over the reporting period of 2018/19. This is a substantial increase, however the number of ABE interviews conducted for OPS decreased by 8% over this period, with PSD ABE interviews increasing from 2 to 4 demonstrating a 100% increase over this reporting period. Approximately only one third of referrals made to CRU are agreed as Joint Protocol. It is generally acknowledged that the new Joint Protocol is being interpreted very differently by respective agencies, hence resulting in a high percentage of referrals made by DAPOs not meeting Joint Protocol as determined by police. Given outcomes APGT find themselves querying decisions made by police and have on a number of occasions challenged decisions in support of vulnerable service users. APGT staff are experienced practitioners who frequently negotiate decision making with the police and use the escalation process as detailed in the Joint Protocol. Again, it is anticipated that the review of the Joint Protocol currently underway will address the concerns identified and will reach a consensus position in terms of definition and application of the Joint Protocol.

The reduced number of investigations agreed by police has had a substantial impact on the number of PIA and ABE interviews conducted. Aside from the implication of this on vulnerable service user groups, there has also been a significant impact on social work ABE interviewers who are unable to meet their practice requirements as outlined in the protocol. APGT note that police have advised DAPOs that referrals are being passed to uniformed Police Officers and Registered Intermediaries are being used as an alternative to ABE trained social workers. The review of the Joint Protocol will consider this and all related issues.

CORE TEAMS - Older People's Service Community Social Work Teams

The Adult Safeguarding Protection Team still retain the responsibility for receiving and screening all adult safeguarding referrals in Older People's Services. During this reporting period the Older People's Social Work Service continues to move ahead with structural and organisational change. The professional oversight has been strengthened with four 8a Team Leader posts across all Community Social Work and the service is pleased to report that this management structure is now stable. However, during this reporting period a vacancy of rate of 50- 75% in team leaders in Community Social Work has prevented the full implementation of the Regional Policy. Adult Safeguarding referrals continue to be screened and thresholded by the Gateway Team. It is the view of the service area that this was the only way that we could ensure a consistent response and thresholding during this very unstable period. Whilst the service area intends to move forward with full implementation of the policy, we remain concerned that further work needs to be developed in relation to identifying standards and processes for managing adults at risk of harm and developing alternative pathways. This is a priority for the service area in the forthcoming year

The management of safeguarding concerns raised in the care home sector continue to present significant demands. The development of a preventative CREST model has ensured that early warning signs of a change in standards in a care home setting are identified with earlier interventions. The issues raised through the Dunmurry Manor investigation Home Truths Report continues to be a focus in the broader discussion of how risk is identified and managed across the Service Area. Staff have been involved in DOH and Trust facilitated workshop sessions reflecting on particularly how our current thresholds of risk and risk management plans are a critical to our broader responsibilities under Safeguarding.

The CREST model has been significant in ensuring the development of strategies which deliver timely reviews, responsive supports and prevention work in Residential and Care Home sector. The ASCOT tool along with the guidance and mentoring of Kent University is being introduced to the CREST team as a methodology to support and assure. Further training and development in this area is anticipated. This outcomes tool will both support the care homes in identifying particular areas for improvement and provide a mechanism to work together on improvements. Also it will bring a rigour to the work carried out by our Social Work staff in observations, monitoring and reviewing within the sector to prevent safeguarding concerns arising.

Quality Improvement methodology has been applied to reviewing and improving the understanding of how older people and/or their family can feel safe in raising concerns or complaints within the care home setting. This again has at its core service improvement and also supports the prevention of concerns being raised later or not at all and escalating to the need for protection.

Staff have also benefited from being able to attend training and events held by partner agencies such as Women's Aid and Action on Elder Abuse.

Challenges

The service area is training staff to be able to bring a range of tools to the protection of our older citizens through a range of methodologies. Community Services have made use of the High Court to ensure the protection of those who lack the capacity to make decisions to protect themselves. This work will inevitably change as aspects of the Capacity Legislation is enacted. As a Service Area we are working to remain flexible and creative in how we respond to the circumstances of individuals to ensure their safety.

The importance of a competent and confident workforce who are well versed in early identification and intervention is essential.

Strategic Direction

We are confident that within the Care Home Sector the ASCOT methodology represents a welcome focus on quality of care and a supportive system of bring further strength to the prevention work which is ongoing. Within the Community Social Work Teams we have appointed a governance post which will bring further assurances in the form of regular auditing of our safeguarding work to highlight areas of good practice through peer support initiatives. It will also help to identify areas of variance in practice. A Principal Social Work has been permanently recruited in the Community Teams and a temporary equivalent post in our Hospital setting. This will bring a renewed focus to the training and development of our staff and the governance arrangements related.

As we progress to integrate the Regional Policy in the service we will have a renewed focus on the feedback from people who are supported through our safeguarding processes and look at how we improve the lived experience of safeguarding. Feedback from 10,000 Voices will help inform this work going forward.

HOSPITAL SOCIAL WORK

Processes and staff resources are in place to provide a response to Adult Safeguarding queries and referrals across the hospital sites in Belfast Health and Social Care Trust. These include: Royal Victoria Hospital, Belfast City Hospital, NI Cancer Centre, Mater Infirmorum, Musgrave Park Hospital and Meadowlands. Monthly returns are provided to the Adult Protection Gateway Team (BHSCT) by way of collection and monitoring of referrals for BHSCT referrals.

We have Designated Adult Protection Officers and Investigating Officers trained and available on each of the hospital sites and cover arrangements in place if required.

There have been a number of instances of residents from other Trust areas coming into regional hospital facilities in the BHSCT area (e.g. Royal Victoria Hospital or Musgrave Park Hospital) for care and treatment and disclosing Adult Safeguarding issues. We have worked with the Gateway Teams from other Trusts to ensure referrals are made to the appropriate area and immediate protection planning is done. We have initiated a new reporting process for 2019/20 to capture the number of referrals to other Trust Adult Protection Teams.

One of the challenges we have is that service users can often have short admissions to hospital were Safeguarding disclosures are made. This can often be a vulnerable time for people due to injury and/or ill-health. Social Work staff in the Safeguarding roles provide a sensitive and professional response in these situations taking cognisance of issues such as capacity to engage in the investigatory process, what immediate protection response is required and how Adult Safeguarding issues may impact on discharge planning.

A recent RQIA inspection report highlighted the issue of awareness of Adult Safeguarding within the outpatient departments on the hospital sites. An action plan has been put in place to provide these departments with Safeguarding posters and postcards for display in waiting areas.

LEARNING DISABILITY

The Service Area continues to have a number of dedicated Learning Disability Adult Safeguarding staff. This comprises of 9 DAPOs: 5 are SW Team Leaders in the hospital and community teams; 1x 8a Operations manager; 1x DAPO in Muckamore Abbey Hospital (MAH) who deals with patient on patient incidents; and 2x DAPOs in the Specialist Team who deal with allegations against staff or paid carers or where there are issues in relation to the quality of care provided in a group setting.

From September 2017 the Specialist team (2x Band 7 DAPOs) have been involved solely in the large scale adult safeguarding investigation into Muckamore Abbey Hospital. This has involved dealing with the historical CCTV incidents and historical incidents. This meant that the work, usually undertaken by this Specialist Team, had to be dealt with by the core Community Learning Disability teams. This added additional pressure to their existing workloads.

The service area has 36 Investigating Officers who are embedded across the service area. There are now 3 ABE trained social workers.

Adult safeguarding (ASG) remains a major area of work for the Service Area. There has been an increase in the number of adult safeguarding referrals from 916 referrals last year to 977 this year with 560 investigations completed. 789 of these referrals were received from the hospital and 188 from the community. A large number of referrals have resulted from the large scale adult safeguarding investigation in Muckamore Abbey Hospital. This includes 236 referrals generated from the viewing of historical CCTV footage that has been downloaded from April- September 2017 relating to 5 wards in Muckamore. In addition, there remains a high number (519) of patient on patient incidents across the hospital site.
The figures are as set out in table below.

Number of safeguarding adult referrals within the period	977
Of the referrals at 6.1, how many were received from acute settings?	789
Number of investigations commenced within the period	560
Number of investigations completed within the period	560
Of the completed investigations at 6.4, how many required a Multidisciplinary Agency Risk Assessment Conference (MARAC)?	1
Number of adult protection plans commenced within the period	536
Number of adult protection plans in place on 31st March	536

<u>Current allegations against staff in Muckamore Abbey Hospital</u>

There have been current ongoing incidents relating to allegations against staff within the hospital site. These allegations have been investigated by the community teams with the support of 1x Band 6 Investigating officer.

CCTV is now running across all the wards at Muckamore. The adult safeguarding team can therefore view CCTV as part of their investigation. The introduction of CCTV across all the wards has been extremely positive in that it has allowed for independent checking of allegations, which has aided in the ASG process. It has also provided reassurance to the families, senior management team, Trust Board and Department of Health. This helps to clarify information quickly and incidents can either be very quickly screened out or the CCTV can be used to provide details and evidence in relation to the allegations made. From viewing the CCTV learning can be achieved in relation to what precipitated the incident, the intervention of staff etc. This helps to set a context to the incidents. The adult safeguarding team now meet regularly with the Service manager, ward managers and operations managers to ensure there is good communication, shared learning and protection plans are reviewed.

There are significant resource implications for the ASG team given the length it time it takes to view the CCTV (as there are a large number of cameras in any given area), time to identify the staff, accurately record the viewing and at times to obtain input from the MAPA trainer in respect of any Physical Interventions used. A number of issues viewed would fall under staff conduct issues and would not reach the threshold for an adult at risk or an adult at need of protection. However, they would be matters of concern for the Adult Safeguarding team, which remains a challenge whether such matters should come under Adult Safeguarding.

The vast majority of the ongoing referrals made against staff relate to [redacted]

As per the Regional policy, any incident deemed to meet a criminal threshold have been referred to the PSNI.

The CCTV policy has been reviewed. For assurance purposes contemporaneous CCTV is also underway across the site. Any good practice is documented and shared through the service manager to each ward area.

The Adult safeguarding team are now planning to complete a more in-depth audit of data to identify any trends or patterns. This will ensure the adult safeguarding responses are better informed and consider a range of factors including the skills mix, staff ratio, time of incident, environment, the patients presentation, etc. which may impact on the safety of patients. This will inform the entire multidisciplinary teams' decision making to improve patient safety.

<u>Historical CCTV allegations against staff in Muckamore Abbey</u>

This has continued to be an extremely challenging year for the service area in respect of adult safeguarding incidents reported because of viewing historical CCTV within the Hospital. The large-scale ASG investigation commenced in August 2017 following the delay in reporting an Adult safeguarding incident. CCTV was viewed at this stage in relation to this incident and during this viewing a number of other adult safeguarding incidents, which were not reported, were noted. This included mostly incidents of a physical nature on patients by staff and the inappropriate use of seclusion. These incidents were later reported as an early alert to the Board. For assurance purposes a further 25% random viewing of CCTV took place across the Muckamore Abbey Hospital

(MAH) site which revealed further incidents in one ward. [redacted] Further allegations were made by a whistle-blower against 2 staff members. A number of these allegations resulted in a joint PSNI/ Social services investigation.

Following these incidents an independent Serious Adverse Incident Level 3 Investigation was commissioned focussing on adult safeguarding from 2012-17 including the above incidents. This panel was chaired by [redacted] The findings of this report 'A way to go' have now been shared with the affected families through workshops and individual meetings and with the staff across learning disability. A written copy of the report has been made available to families, including an easy read version for patients.

The main themes emerging from this report were as follows:-

- The criteria for admission to the hospital was too low with patients being admitted for a large number of reasons including, those who required assessment and treatment, those whose placement had broken down, short breaks etc. In addition, once admitted these patients were extremely difficult to discharge and therefore the length of admission became protracted with many having no discharge plans.
- There was a high incidence of patients being bored in the hospital due to a lack of meaningful activity on and off the wards. This undoubtedly led to frustrations and an increase in patient on patient incidents but also of incidents of staff on patients.
- There was an inappropriate use of seclusion sometimes for long periods of time and poor recording detailing the rationale for the decision surrounding this.
- Despite a large number of RQIA inspections and a very high number of Adult safeguarding referrals, (even resulting in referral to the police) there was a lack of action taken which actually reduced the number of incidents or improved the safety for patients.
- Families were not allowed access to the patients' bedrooms or to the actual ward. This was particularly so in one ward.
- There was a lack of visible leadership across the site

Some of the recommendations from the report that now form part of the Trust action plan are as follows-

- People with learning disabilities should be able to live their lives with their families and in communities and the services provided should understand that ordinary lives require extraordinary supports – which will change over the life course.
- The hospital should review its criteria so that admission is for assessment and treatment only, for the shortest time possible.
- The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services.
- There should be better advocacy services.

- Development of a co-produced communication strategy with parents/carers/ appointment of carer consultant aimed as repairing and establishing relationships and trust with patients and with their relatives as partners. Families should have greater input in relation to decision-making.
- Families and advocates should be allowed open access to wards and living areas.
- Patients should be engaged in more meaningful activities during their admission.
- Patients and families should have better information in relation to how to complain.
- Families should receive regular progress updates.
- The families wanted an end to seclusion.
- There should be a review of Adult Safeguarding culture and practices at Muckamore so that the responses to safeguarding incidents and allegations are proportionate and timely, that the perception that people with learning disabilities are unreliable witnesses is changed and that the safeguarding documentation is substantially revised.

Much progress has been made in relation to these action points but there is still a lot of work ongoing. Whilst this SAI investigation was ongoing it was agreed that all the downloaded CCTV (April-Sept 2017) be viewed for all 5 wards. This proved to be very challenging for all adult safeguarding staff in learning disability services. The Muckamore investigation has been unprecedented in terms of numbers of allegations and its complexity. This has resulted in a huge amount of work relating to the historical allegations and the historical CCTV incidents being undertaken by the 2 DAPOs in the community. This has had a knock on effect on the community teams as they had to take on the work previously covered by this specialised team.

Since the start of the investigation, the 2 DAPOs have processed 191 referrals for one ward with 177 of these being referred to the PSNI. 14 other incidents were not referred to PSNI. These incidents are all mostly of a physical nature and include inappropriate use of seclusion. In addition, a further 158 incidents relating to the other wards have been triaged by the ASG team. To date only a small number of these incidents have been viewed by the adult safeguarding team. However, of what has been viewed an additional 44 referrals have been forwarded to the PSNI. These incidents are again mostly of a physical nature and involved a number of staff who were either involved in actual physical incidents and or other staff who allegedly witnessed the incident and or failed to intervene.

The CCTV was taken by the PSNI in February 2019 and at this stage the percentage viewed for each of the 5 wards was as follows –82%,-64%, 66%, 48% and 46%. This clearly continues to create difficulties for families who know that there is further historical CCTV to view. The Trust remain committed to the viewing of all CCTV during this specified period.

The PSNI have an identified taskforce dealing with this investigation and have a team of additional officers. They have been working very closely with the PPS and are looking at a whole range of potential offences in relation to this investigation including Article 121, wilful neglect, common assault and misconduct in a public office.

Unfortunately, over the reporting year attempts to recruit additional DAPOs to assist with this investigation have been largely fruitless resulting in the 2 DAPOs undertaking the viewing of CCTV, as well as preparing large voluminous files for the Police and HR department. This has been a hugely complex task and both the PSNI and the HR department have complimented the team for the complex work completed.
All the affected families have a nominated DAPO attached to them and with their agreement there were updated on a regular basis regarding any further developments as well as offered supports including psychological support from the Trust. The DAPOs have been working in close partnership with the PSNI and a number of visits to families were done jointly between the Trust and the PSNI. At the end of the reporting period the service area managed to secure a part time DAPO whose sole role is family liaison with some of the affected families.

As a result, of the current ASG investigations 20 staff have been placed on precautionary suspension and other staff are subject to protective measures. This along with staff sickness has given rise to a number of challenges for the service in ensuring that there is adequate staffing across the site to ensure patient safety.

There has also been ongoing liaising with the other Trusts to update them regarding the current investigation but also to address any specific issues relating to their service users. Whilst the CCTV remains outstanding, there is also a feeling of uncertainty across the staff group at the hospital. Staff across the site have been supported at this difficult time through a large number of initiatives including a counsellor who provides 1:1 emotional support, reflective practice sessions, workshops with staff, massage sessions and support sessions with HR and OH. In addition, a health fair is planned and 'Bewell' sessions planned.

The Service Area has continued to work within the Adult safeguarding Regional Policy, the HR disciplinary processes and Joint protocol. This has resulted in many challenges balancing the requirements of each process and being proportionate in relation to staff but at the same time protecting patients.

The hospital SW staff have continued to roll out the ASG 'Keeping yourself safe programme' across MAH. There has also been further ASG training provided across the hospital site. There is further CCTV to view and the 2 DAPOs who had been doing the investigation are now due to be replaced by a new ASG team which was appointed at the end of March. This team currently comprises of 1x Band 8B and 3x 8A staff. There remit is take forward the remaining historical CCTV and provide support to the affected patients and families.

<u>Muckamore Abbey Hospital current patient on patient referrals</u>

The social work department in the hospital continues to lead in relation to safeguarding patient on patient incidents. In this reporting year, there have been 519 incidents in the hospital. Most of these incidents are of a physical nature. Many of these incidents include multiple incidents relating to the same patients either as alleging causing harm or and victims of alleged abuse. All these referrals are processed by one Band 7 Lead DAPO, who is supported by the Senior Social Worker and by 2 Investigating Officers. Together they support the Multi-disciplinary team in the development of risk management, alternative safeguarding responses and protection plans. Support is also provided to the patient and a referral to the PSNI if deemed appropriate, or at the request of patient or

carers. As part of the screening and or as part of the investigation into the incidents CCTV will also be viewed by the DAPO.

As a result of staffing difficulties (suspensions and staff off sick) and also as a means of stabilising the hospital, the hospital has been closed to admissions. In addition, over the last year the hospital has been retracting as patients have been discharged and therefore the number of inpatients has significantly declined. However, there remains a high level of incidents of a physical nature between patients in the shared setting of the hospital. There are ongoing difficulties related to the physical environment and the mix of patients in the wards, many of whom have complex needs and present with challenging behaviours associated with autism and other conditions, communication difficulties and limited insight into the possible consequences of their actions or that of others. Very few of the patients have skills to protect themselves Staffing levels can also often mean that patients are unable to avail of opportunities to be off the ward and this can increase the number of incidents on the ward.

Despite good multidisciplinary working including robust risk assessment and risk management plans, it continues to be a challenge implementing suitable protective plans to reduce the likelihood of further incidents. All these ASG incidents are now reviewed on a weekly basis at the multidisciplinary team but also the data forms part of the SITrep report, which allows the Senior Management team / Directors Oversight group the opportunity to understand trends and patterns in relation to this and consider what further steps can be taken to address the matter.

In order to reduce the number of patient on patient incidents in the wards considerable work has been done:

- In Jan 2019 an activity Co-ordinator was appointed following a review of day care at the hospital. This has significantly improved the level of activities for inpatients across the Hospital Site. Therapeutic Day services are now also provided within the hospital at weekends and evenings activities on the ward and off the ward. This has helped to reduce contact between patients and thus reduce frustrations levels and the likelihood for incidents. Activities for patients ensures the holistic needs of patients is catered for with intervention, which may include recreational input, social input or skill development. By extending the frequency and range of appropriate and meaningful activity the mental, physical and emotional wellbeing and social needs of patients is promoted.
- Joint Therapy Aims and Free time Plan/Activity Boxes have been introduced which allows ward staff to work on individualised therapy aims with patients, which forms an important part of their treatment. The box can also be used to de-escalate a situation or redirect a patient from a difficult situation, which promotes the safety and well-being of patients.
- Plans are place to resettle a large number of patients whose discharge has been delayed. There has been work done by the service area with a large number of providers along with the other Trusts to put in place plans to successfully resettle patients in the community.

- The Trust has also developed a supported living scheme in Cherryhill, which is due to open in June 2019 and will be accommodating 9 patients who are to be discharged from the hospital.
- The hospital SSW and lead DAPO have regular meetings with the service manager and the 8a nursing operations managers to address any ongoing concerns in relation to patient safety.
- The hospital SW team are currently piloting real time feedback from patients and from carers prior to and post Adult safeguarding intervention to understand what would make them feel safer.
- Safeguarding procedures, including use of special observations, has been used to minimise targeting of vulnerable patients.
- The ASG team will now be auditing data in relation to ASG and identifying trends and patterns so that a collective understanding can be achieved in relation to the issues re ASG across the site and then identifying how this can be addressed.
- There continues to be discharge meetings convened to expedite community placements and notify Trusts of the number of safeguarding concerns for each patient remaining in hospital.
- Ongoing training of nursing staff in Muckamore regarding the thresholds, their responsibilities under adult safeguarding protocols, completing the forms correctly and developing robust interim protection plans.
- Viewing CCTV assists the ASG team to understand the factors precipitating/ leading up an ASG incident and the context of the incident, which is then shared with the ward managers/ management team.
- Positive behaviour practitioners provide support to reduce incidents of challenging behaviour.
- The Keeping You Safe Training to patients remains a key function of the SW team in the hospital. Within the last year, 21 patients have been provided with the training. Various methods have been used, group and individual sessions, depending on the ability of patients.

Social Work staff in MAH are now aligned to each ward, which ensures there is a full MDT approach to address the issues and reduce the potential risk to patients e.g. through making environmental improvements, use of positive behavioural support, increased day activities etc.

In the last year, the service have implemented a new process in the management of safeguarding. This process is in keeping with the Adult Safeguarding Policy and provides opportunity for ward managers to become nominated Adult Safeguarding Champions. The vast majority of incidents managed through this process are minor in content and only require an Alternative Safeguarding response. The hospital SW department continues to provide support and advice to ward managers and nursing staff. The Senior Social Worker has been auditing this new initiative and raising any issues with hospital management.

Community based investigations

Allegations against staff

The service has continued to investigate concerns raised in nursing homes, residential homes and supported living projects. The referrals cover a range of abuse including alleged physical abuse, psychological abuse, financial abuse of service users and institutional practices.

The service remains concerned about quality issues which, while they do not meet the threshold for safeguarding, may have significant impact on the quality of life for service users. Many of these facilities continue to experience high turn overs of staff, low staff morale and poor resilience. The Trust continues to work with providers to build their capability and improve their resilience.

Allegations of service user on service user abuse

Most of these referrals relate to low level physical incidents of one service user on another which reflect the reality of group care for service users who can display behaviours, which challenge and have communication difficulties. As noted in previous reports, where the victim and person who is alleged to have caused harm have learning disabilities, behavioural issues and share the same space it can be difficult to put in place protective plans. Again, as noted in previous reports suitable alternative placements are required.

All group living services are aware of the need to review care plans, environments and the mix of service users in order to promote a safe living environment for all.

The Service Area believes that many preventative measures are required to address these issues such as good quality staff recruitment, retention, support and training.

MENTAL HEALTH

There continues to be a significant increase in the volume of Adult Safeguarding referrals, investigations and protection plans in the last twelve months with an increase in referrals by 20% and in investigations by 10%. The Mental Health Adult Safeguarding Team continues to provide the majority of DAPO cover and has endeavoured to continue to improve awareness of Adult Safeguarding procedures in recognising and reporting of abuse in community teams that are non-Social Work led. DAPO's from the Mental Health Adult Safeguarding Team continue to embed the process and knowledge of the procedures and to assist Team Leaders in fulfilling their responsibility for initial screening, implementing interim protection plans, governance responsibilities and onward referral to DAPO.

The Mental Health Adult Safeguarding Team currently consists of a PSW – who is also the named Adult Safeguarding Lead for the mental health service area in addition to the PSW role, 2 Band 7 Senior Practitioners/DAPO's, a Band 7 Senior Practitioner/Professional Social Work development lead and Think Family lead, who also provides sessions into Adult Safeguarding for DAPO. All DAPO's in the Mental Health Adult Safeguarding Team are ABE trained.

The Mental Health Adult Safeguarding team currently acts as a single point of contact for Adult Safeguarding referrals for mental health services who do not have trained DAPO's within their team. There are plans for all mental health referrals to be sent to the Adult Safeguarding Protection Gateway team in the future for screening and decision making on the level 3 cases to be taken forward for investigation, but to date the current process remains and there is no date for APGT screening of all referrals. The Adult Mental health team currently screen all referrals received and identify an IO and DAPO. They are also the point of contact for guidance and referrals from outside agencies and are advised on issues which would require a safeguarding investigation and arrange for the allocation of an IO and DAPO to commence the safeguarding process. The Mental Health Adult Safeguarding Team continues to act as the central point of contact for PSNI for PIA / ABE interview consultations and requests and allocates referrals to trained staff within the mental health service area. There continues to be well established support groups for IO, DAPO and ABE trained staff across the Trust and staff are encouraged to attend these groups to keep them updated regarding any changes or issues and is also a forum for shared experience and learning.

The Mental Health Adult Safeguarding Team meet weekly to review and discuss Adult Safeguarding investigations and management of cases. The team has a Band 7 Senior Practitioner for MARAC cases and referrals for MARAC process.

The Mental Health Adult Safeguarding Team also provides supervision and support to DAPO's and IO's across all services who are not line managed by a qualified Social Worker DAPO. They also provide an advisory and consultative role for all professional staff across the 41 mental health teams / services and outside agencies including voluntary organisations and PSNI.

Referrals are received from a wide range of service areas, including hospital settings, the medium secure facility, supported living facilities, nursing and residential settings, day

care and from a range of community mental health services – within acute, primary and recovery teams.

There has been an increase in the number of protection plans by 15%. The figures reflect a reduction in PIA/ABE interviews. The figures for 2018/2019 show a reduction of 50% in PIA interviews and a 70% decrease in the number of ABE interviews completed within mental health. This is largely due to the police thresholds for joint protocol investigation and a high proportion of referrals to CRU have been assessed by the PSNI as only requiring a single agency investigation. The PSNI thresholds assess domestic abuse, historical abuse, physical and sexual assaults as single agency investigations. The PSNI/CRU thresholds also assess any patient in receipt of 24 hour care in a hospital setting are not vulnerable adults in need of protection and will only agree this a single agency PSNI investigation. DAPO staff in their consultations with CRU continue to challenge these decisions and the need for a joint investigation with PSNI on a case by case basis. However, it remains our experience that the PSNI will make the final decision. It is predicted that there will continue to be a decline in PIA/ABE interviews under the new thresholds for assessment by PSNI. Given the reduction in joint protocol investigations mental health services will not be nominating social work staff to undertake the ABE training this year. Staff currently trained have reported that they are having difficulty meeting the two ABE interview requirements to continue with the role given the reduction in ABE interviews.

Within Mental Health services there is a significant deficit in DAPO's across the service as not all of the services are led by Social Work staff. There are 6 social work Team Leaders across the 41 mental health teams, 10 senior practitioner staff including the 3 Senior Practitioner DAPO'S in the Mental Health Adult Safeguarding Team and a two year time limited temporary addition of 2 CSM Social Work posts who will undertake a DAPO role within their service area if there is no Senior Social Worker/DAPO in post. An expression of interest has been circulated for an additional two temporary Senior Practitioner Social Work staff to undertake additional roles within the community teams – this will include a DAPO role along with other enhanced duties and there continues to be increased pressure on DAPO's within the mental health service area who also undertake a number of functions i.e. Team Lead, ASW, ASW assessors, Professional Social Work Supervision and DAPO. There is also a deficit of Band 6 staff due to vacancies within the community teams and of IO trained staff within nursing staff in mental health with Nursing staff declining to undertake the IO role supported by their unions, therefore Social Workers tend to undertake the majority of Adult Safeguarding investigations. In addition some community teams have AYE Social Work staff who are currently unable to undertake the IO role until they are at Band 6 level while other teams report only one Social Worker within their team and the remainder of staff are support staff who are also unable to undertake the IO role. This has continued to impact on Social Work front line services delivery and has placed considerable pressure on the Social Work workforce who also undertake all of the other statutory functions within mental health. There continues to be an increase in referrals from the voluntary sector and from the Leaving and After Care teams who have no provision of IO/DAPO within their service area and victims may not be currently open to mental health services. However as they meet the key definitions of an adult at risk of harm or an adult in need of protection an IO has to be sourced from the existing mental health IO trained staff which also increases pressure on their service delivery and caseloads.

There are on-going challenges within mental health services with the introduction of the Adult Safeguarding policy July 2015. Joint agency working with PSNI, RQIA, professional bodies regarding procedures, protocols and practice issues remains an ongoing priority. The mental Health Adult Safeguarding Team have implemented a database to capture the recording of Adult Safeguarding as an interim measure while plans continue to implement all of mental health safeguarding recording and investigations to the Trust information system – PARIS. All staff within mental health services will require some additional training for the implementation of recording of adult safeguarding referrals and investigations on PARIS, however there is no current timescale for this due to the new APP documentation which needs to be designed for PARIS but planning meetings continue with the PARIS implementation team. The service area remains committed to the delivery of adult safeguarding, while recognising significant workforce pressures. A priority for the service is to ensure that Band 6 non-Social Work staff are encouraged to undertake IO training and that there are suitable supervision and support arrangements put in place to support non-Social Work IO staff. Additional bespoke IO and DAPO training has been facilitated by the Learning and Development Team in addition to the IO/DAPO training offered twice per year to relieve pressures on community teams so that newly appointed staff could undertake the IO and DAPO roles.

Workforce planning continues to be encouraged with the Service Leads within each service area to ensure that appropriate levels of Band 6 staff and Band 7 Social work staff are recruited to undertake the assessed safeguarding requirements for their service. Consideration is also required of the capacity of Band 7 Senior social work practitioner staff to meet the demand within the service area and fulfil the statutory requirements of the Band 7 role to undertake the ASW and DAPO / ABE function.

The Mental Health Adult Safeguarding Team continue to offer essential support to all DAPO's and IO's within the Service Area and in quality assuring all aspects of Adult Safeguarding. The Mental Health Adult Safeguarding Team has completed an initial audit of safeguarding within the service area and plans to do this on an annual basis to ensure governance arrangements, appropriate safeguarding investigations are undertaken and review decision making, and alternative responses to safeguarding. Refresher training for IO/DAPO is also being planned with the Learning and Development Team which would be an addition to the IO/DAPO support groups currently in place so that IO/DAPO's can maintain and update their skills and knowledge in safeguarding. It is anticipated that the current level of DAPO/IO need within mental health services will remain at the same rate when the Adult Protection Gateway Team become the single point for referrals for mental health. The Adult Protection Gateway Team will take responsibility for level 3 investigations which include joint protocol investigation, institutional care investigations and investigations involving paid members of staff and have a team of DAPO and IO staff to manage the investigation. All other referrals will remain the responsibility of the mental health service to progress the investigation. Within mental health services the level 3 investigation for joint protocol and paid staff allegations of abuse have decreased due to the police thresholds for joint protocol investigation and the level of referral for institutional abuse referrals remains low, therefore the majority of referrals currently referred and dealt with by the mental health Adult Safeguarding team will remain at its current level.

SECTION 5: LASP Partner Updates

Belfast and Lisburn Women's Aid

- All the staff team are given Adult Safeguarding training which is Core. (every three years) Last training session 2018.
- Four staff 1. Board member, Two Senior managers, Outreach worker have completed Adult Safeguarding training Champion/Appointed persons.
- We have one [redacted] and three appointed persons.
- All staff and volunteers are aware and can identify the above.
- We have created a template for collating all adult safeguarding queries, discussions, referral activity.
- Each of our three refuges use the pro forma to record ASG activity.
- All information is sent to the ASC.
- All information gathered is used in the yearly ASG report.
- Adult Safeguarding is regularly on staff meeting agenda's; Senior Management team meetings, Board meetings, individual team meetings, and full staff meetings.
- We have an Adult Safeguarding policy which outlines procedures for dealing with Adult Safeguarding referrals etc.
- ASC attends all LASP meetings throughout the year.
- Our key worker in the Older Women's Project has had the following additional training/awareness raising sessions – Dementia Awareness – Advice NI – Integrated services for Older people-Action on elder abuse conference.

Cedar Foundation

Our Quality Improvement Plan included:

- Assurance that all staff and volunteers have the appropriate Level of 1,2,3 Safeguarding Training-Achieved 100%
- Continue to use ISO accreditation as the framework for ensuring systems and processes to monitor and evaluate our Safeguarding Practices; we updated our Policy to reference the European Convention on Human Rights, and to include our Complaints Procedure
- We reviewed incidents monthly and reported quarterly to the Executive Board
- We completed the Adult Safeguarding Champion Position Report for 18/19
- We participated in LASP and ARC Networks to ensure the currency of knowledge regarding best practice approaches to Adult Safeguarding

Lisburn & Castlereagh City Council

Please record your organisations/service activity under the Prevention, Protection, Partnership headings for the year 2017-18. This will be included in the LASP report. If you also know or plan to complete activity in the forthcoming year please also record in the 2019/20 section.

Activity	2018-19	2019-20
Prevention	• Reviewed all 14 SG Procedures • Produced New Procedure – 'Dealing with a Person in Crisis / at risk of suicide' • 4 In house LCCC Keeping safe trainers attended an up skilling/bridging course with Volunteer Now to add adults at risk training to Child protection training to ensure staff only have to be released once for training. • SG champions (SP and BT) Attended Appointed persons training and mental capacity training • SG Champions attend SG Champion network meeting re Position report • Completed the 18/19 Position report • Attended Elder Abuse Conference in February • SG Champions have both attended Mental Health First Aid training • February 2019 - Arranged a meeting with GRO (births, deaths and marriage registration) to discuss the sharing of personal information to ensure a referral can be made to the relevant statutory bodies if abuse is suspected. This was following concerns about a GRO Memo that was sent to Council staff. • Have now achieved Platinum membership of ONUS –	To review and update LCCC Safeguarding Policy - New CEO Revise the e learning management system for Safeguarding and roll out to all staff. Members of in-house working group to attend Appointed person training. SG champions to attend any relevant training

	workplace domestic Abuse. Have carried out a number of awareness raising session in community for businesses and churches	
Activity	**2018-19**	**2019-20**
Partnership	• Attend SET and Belfast Trust LASPS meetings • Elder Abuse day 15 June 2018 - Bow street mall - partnership with PCSP, SET LASP, Banks and Trading standards on scam awareness • SG champion on working group for action plan -' accessing safeguarding services' • SG champions are active members of NI Safeguarding Network • PCSP now members of our internal working group	Work in partnership for Elder abuse day 2019 - loneliness theme

Volunteer Now

Core KAS Sessions

Throughout 2018-19 Volunteer Now has continued to work in partnership with the Health and Social Care Board and Belfast LASP to deliver free 'Keeping Adults Safe' training to participants from voluntary, community, independent and faith sector organisations in the Belfast Trust area.

The following courses were delivered:

- **3** full day **KAS M2** 'Keeping Adults Safe: Training for Staff and Volunteers'
- **2** full day **KAS M3** 'Keeping Adults Safe: Recruitment, Selection and Management'

There were **79** participants in total and the average participant evaluation score was **4.6** (on a scale of 1 to 5, where 5 is excellent).

Additional Activities

Volunteer Now has been actively involved with the Belfast LASP throughout the year, attending LASP meetings and events.

Volunteer Now Enterprises Ltd also continues to promote the 'Keeping Adults Safe: Adult Safeguarding Champion & Appointed Person' training through the LASP.

Core KAS Sessions – Break down

A full break down of the **core KAS sessions** in the Belfast LASP area is included below:

19th October 2018, Module 2: Keeping Adults Safe: Training for Staff and Volunteers
Belfast (Volunteer Now)
16 participants
Average Score: 4.6

Participant Comments: Enjoyed the group discussions, hearing people's different opinions on situations. / Invaluable to keep everyone up to date with expectations. / Nice relaxed refresher to safeguarding / lots of respect and space to discuss issues, plenty of clarity and guidance / Useful for my organisation.

8th November 2018, Module 3: Keeping Adults Safe: Recruitment, Selection and Management

Belfast (Volunteer Now)
11 participants
Average Score: 4.6

Participant Comments: Invaluable information, well organised and presented / Will go back and look at our policy / Excellent update / Found Access NI info particularly useful / Content of the training was very relevant.

17th January 2019, Module 2: Keeping Adults Safe: Training for staff and volunteers

Belfast (Knockbracken Health Care Park)
14 participants
Average Score: 4.9

Participant Comments: Very interesting training and in depth, really useful and has improved my knowledge greatly. / The training was very thorough – I enjoyed the discussions with the entire group to get different opinions. /

11th February 2019, Module 3: Keeping Adults Safe: Recruitment, Selection and Management

Belfast (Knockbracken Health Care Park)
21 participants
Average Score: 4.4

Participant Comments: Good level of interaction. [Trainer] made you feel very comfortable]. / Well put together course. Good interaction with the group. / Interactive group discussions, useful and informative. / Enjoyable interactive training which raised awareness and evoked thought. / Very well presented. / Trainer was knowledgeable. Room was cold in the morning, warmed up in the afternoon. / Excellent training – enjoyed all the interaction and group exercises. / Lots of food for thought for my organisation as we consider expanding the range of services that we provide. / The resource pack was great. Really enjoyed the case studies and discussions. / Good use of resources. / Good opportunity to revise and recap on existing knowledge and to network with others.

19th March 2019, Module 2: Keeping Adults Safe: Training for staff and volunteers Belfast (Knockbracken Health Care Park)

17 participants
Average Score: 4.7

Participant Comments: Room was cold. / Great lunch facilities, / Easy to understand, and use in my workplace. / Enjoyed the training – very informative and related to my work place. / A high standard of training, very informative and felt very comfortable and able to ask questions. / Trainer very good. / Well laid out training with experienced facilitator. / Very well delivered. / Room was freezing, everyone uncomfortable.

Core KAS Sessions – Analysis

Participant Feedback

The average participant evaluation score for the Belfast M2 sessions was **4.7**, and for the M3 session was **4.5** (on a scale of 1 to 5, where 5 is excellent).

As demonstrated by the participant evaluation comments included above, feedback has continued to be excellent with respect to the trainers, course content, delivery and interactive nature of the sessions.

Booking and Attendance Numbers

The 3 KAS M2 sessions were attended by 47 participants and the 2 KAS M3 sessions by 32 participants, giving a total of **79 participants across the 5 sessions.** This averages at 15 participants per session (the maximum is 25 per session).

A significant issue across all KAS sessions is 'drop out' of participants who have signed up for sessions and then failed to attend or made late cancellations. This can be difficult to manage due to the courses being free to book and has continued in 2018-19 despite our formal booking/confirmation process via our website and reminder emails being routinely sent to participants prior to delivery dates.

SECTION 6: Belfast LASP work plan 2019/20

There will be a strong emphasis on taking forward areas of adult safeguarding work within the Belfast Trust in response to regional and local learning.

There will be a review of adult safeguarding structures and local procedures to ensure that adult safeguarding is fully embedded across all areas within the Trust.

In addition, the Belfast LASP will work to deliver on the NIASP annual objectives for 2019/20 and will consult with Belfast LASP members regarding a local LASP work plan for 2019/20.