Lambeth Safeguarding Adults Board Annual report 2015-16

ANNUAL REPORT

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How to report abuse in Lambeth:

In an emergency – you should always call the Police or Emergency Services on: 999

Where to report adult safeguarding concerns:

The Initial Contact Service is Lambeth Council's central referral point:

Opening hours: Monday to Friday 9am to 5pm

Tel: 020 7926 5555

Email: adultsocialcare@lambeth.gcsx. gov.uk *(this is a secure address)*

Lambeth Council's Website: www.lambeth.gov.uk (report abuse here for adults & children)

After hours: The *Emergency Duty Team*: 020 7926 1000

Where else can you report your concerns:

You *can also report any concerns* about abuse or neglect of yourself or someone else to:

- Your GP or Nurse

- A health or social care staff member in any hospital

- A voluntary or community organisation that is helping you

Safeguarding Adults in Lambeth

Forward by Independent Chair

Siân Walker

Welcome to the 7th Annual Report of the Lambeth Safeguarding Adults Board. Unusually the Board, in this past year, had 3 Chairs so I would like to start by thanking Gill Vickers, the former Director of Adult Social Services for Lambeth, who chaired the Board until September 2015 and also Catherine Pearson, Chief Executive of Lambeth Healthwatch who chaired the Board in the first part of this last year and remains an active member of the Board.

I joined the Board as its Independent Chair in October 2016, with a brief to examine the Board Membership, taking into account the feedback by Ofsted to the Children's Board in 2014; and to assure partners that the membership and meetings were able to act strategically, in a positive way which took account of and enabled improvement of services provided for those who are vulnerable in Lambeth. In particular, it was important to assure members that the Board was delivering in accordance with the statutory requirements set out by the Care Act 2014, placing the board for the first time, this last year, on a statutory footing. Regular meetings are in place with the Independent Chair of the Safeguarding Children's Board to ensure shared learning and a strategic approach to delivering safeguarding across services.

There is enthusiasm for the partnership work in Lambeth to safeguard and protect adults at risk, and the commitment of all Board members was demonstrated so clearly when we were reviewing the functioning and membership of the Board. I believe we have a Board which functions at the appropriate strategic level supported by senior managers working operationally who make an absolute difference in each of their constituent organisations. So the Board continues its progression and its achievements over the last year are set out in the body of this report.

We held a planning day in March 2016 to begin the development of strategic objectives for the forthcoming year. Clear priorities were identified in terms of:

- developing greater community awareness about safeguarding and protecting vulnerable people
- working with care providers to improve the way they can support and protect vulnerable people
- ensuring that we continue to focus on performance information from all organisations which is relevant and enables the Board to agree and target improvements and also to challenge each other
- Continue to ensure that we embed the practice which we call "making safeguarding personal" and which ultimately means that all those citizens who are safeguarded or protected, have the opportunity to determine for themselves the outcomes they want to achieve

Our objectives this coming year will build upon these priorities and deliver improved communication to the general public to increase awareness about safeguarding.

It is especially important that all partners continuously audit practice and take forward the lessons learned. The report, on page 15 & 16, sets out some of the learning we have shared within the Board from organisational audits. In particular we have learned that people are aware of safeguarding, though the Board needs assurance that there is an improvement in people's confidence around their roles and responsibilities in relation to safeguarding. This has led to the necessity to concentrate on delivery of appropriate training for staff and over the forthcoming year we will be measuring the impact of learning and development across partner organisations.

I would like to thank all those people who support the effectiveness of the Board, but importantly who make a difference to Lambeth citizens, because of their passion for improving services for adults at risk.

Siân Walker

Independent Chair

3. What is Safeguarding Adults about?

What is meant by Safeguarding Adults?

The Care Act 2014 introduced statutory duties for local authorities to protect (safeguard) residents in their area, from abuse and neglect.

Section 42 of the Care Act says:

Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)

1) has needs for care and support (whether or not the authority is meeting any of those needs),

2) is experiencing, or is at risk of, abuse or neglect, and

3) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Then:

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to decide whether any action should be taken and, if so, what and by whom.

Who is an Adult at risk?

Anyone who is 18 years and older who needs care and support. They may be ill, frail or have a disability and are unable to protect themselves from significant harm.

Local Authorities have a statutory duty to protect adults at risk from abuse & neglect

What is abuse or neglect?

Abuse is mistreating or neglecting someone so that it has a negative impact on their quality of life. It is seen as the violation of an individual's human and/or civil rights by any other person or persons.

The types of abuse include; physical, sexual, psychological, financial and material, neglect and acts of omission, discriminatory and organisational. It also includes modern slavery, domestic abuse and self-neglect.

4. Examples of Safeguarding Adults

A young woman with learning disabilities reported that she had recently moved into a new flat and a situation had arisen where a neighbour had moved in and was sleeping on a mattress next to her bed. One night she awoke to find him in bed with her and she called the Police, who attended. The Police were concerned about her vulnerability and felt that she did not have the skills to protect herself. As a result of the Safeguarding Enquiry, additional support was offered to her to support her to be safe in her own home.

A gas engineer visited a person to carry out a gas safety check, but it couldn't be carried out because of the condition of the person's home. There was too much clutter and boxes for the engineer to gain access safely. She told the Housing Officer and the matter was reported to Adult Social Care. This resulted in the person receiving some support to help her make decisions to clear some of her possessions, so that access around her home was safer

A person called an ambulance because she had a pain in her back and couldn't stand up. The Ambulance Crew attended her at home and took her to hospital, though they were concerned because she was unkempt and her home was in a poor state. They made a referral to adult social care. When she was in hospital it was discovered that she has a pressure sore at the lower part of her back. She said that her dressing hadn't been changed for a few days. Adult social care were able to speak with the District Nursing team to ensure that she received regular visits upon discharge from hospital to prevent

Mr X lived alone in his own property and had no children or living relatives. He was found walking alone at night and was admitted to hospital where he remained for some months. He was diagnosed with dementia. On leaving hospital he went to live in a care home but because he owned his property needed to contribute towards the cost of his care. He had previously signed over Lasting Power of Attorney to his only "friend"; his gardener. When enquiries were being made about his finances, the Council was contacted by the financial business who had supported him with an investment years earlier, to query why another person was trying to transfer Mr X's investment into his own account. This was reported to the Office of the Public Guardian who began their own investigations and supported having the power of attorney removed, and protecting Mr X's money for his own use.

5. Lambeth's Safeguarding Adults Board

The Lambeth Safeguarding Adults Board (LSAB) is a statutory board under the Care Act 2014. It is made up of senior members from a range of organisations such as the Police, NHS Clinical Commissioning Group (CCG) and Lambeth Adults Social Care. The Board has an Independent Chair.

The core objective of the Board, set out in section 43(2) of the Care Act 2014, is to help and protect adults in its area in cases where:

- The adult has care and support needs;
- They are experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs they are unable to protect themselves from either the risk of or the experience of abuse or neglect

> The Board ensures the effectiveness of local safeguarding arrangements

The Board co-ordinates and ensures the effectiveness of what each of its members does. It must assure itself that local safeguarding arrangements and partners act to help and protect adults at risk.

6. The sub-groups of the Board

The LSAB has the following sub-groups:

1) Performance and Quality Group (PAQ) which is responsible for managing the implementation of the work programme set by the LSAB.

2) Community Reference Group (CRG) which is the link between the Board and the Community.

3) Safeguarding Adults Review Task and finish group which is set up when a Safeguarding Adults Review is underway.

7. Membership of the Board:

The below membership represents the Board membership over 2015/16:

Name	Title	Organisation
Full Board Members		
Adela Kacsprzak	Assistant Chief Officer	National Probation Service
Aisling Duffy	Chief Executive	Certitude
Ann Corbett	Programme Director, Community Safety	LB Lambeth
Bruce Grain	Station Manager	Fire Service
Catherine Pearson	Chief Executive	Healthwatch Lambeth
Cllr Jackie Meldrum	Cabinet Member for Social Care	LB Lambeth
Cllr Jim Dickson	Cabinet Member for Health & Wellbeing	LB Lambeth
Darren Farmer	Quality Governance and Assurance Manager, LAS - South East Area	London Ambulance Service
Fiona Connolly	Interim Director, Adult Social Care	LB Lambeth
Helen Charlesworth-May	Strategic Director; Children's, Adults and Health	LB Lambeth
Lenny Kinnear	Chief Executive	Age UK Lambeth
Lisa Humphreys	Assistant Director, Children's Social Care	LB Lambeth
Lucy Canning	Service Director, Psychosis Clinical Academic Group	South London and Maudsley NHS Foundation Trust
Mala Karasu	Safeguarding Adults Trust Lead	Guys and St Thomas' NHS Foundation Trust

Mandy Green	Assistant Director Homes and Communities	LB Lambeth
Maria Millwood	Director, Strategy & Commissioning Children	LB Lambeth
Melodie-Ann Dalrymple	Senior Probation Officer	London Community Rehabilitation Company's (CRC)
Moira McGrath	Director Integrated Commissioning (Older Adults) / CCG Safeguarding Lead	Lambeth CCG and LB Lambeth
Paula Townsend	Deputy Director of Nursing	Kings College Hospital NHS Foundation Trust
Sean Oxley	Detective Superintendent	Lambeth Metropolitan Police
Shane Foreman	Head of Safer Prisons and Equality	HMPS Brixton
Siân Walker	Independent Chair	
Advisory/Not full Board Members:		
Ann Hamlet	Head of Safeguarding Adults	Kings College Hospital NHS Foundation Trust
Clement Guerin	Head of Quality and Safeguarding Adults	LB Lambeth
Janna Kay	Quality and Safeguarding Adults Manager	LB Lambeth
Helen Wells	Inspection Manager (Lambeth, Southwark & Lewisham)	CQC
Elaine Ruddy	Safeguarding Adults Lead NHS England (London Region)	NHS England
Barbara Joyce	Welfare Specialist, Office of Public Guardian	Office of Public Guardian

8: Making a Difference in Lambeth

8.1 Safeguarding Activity

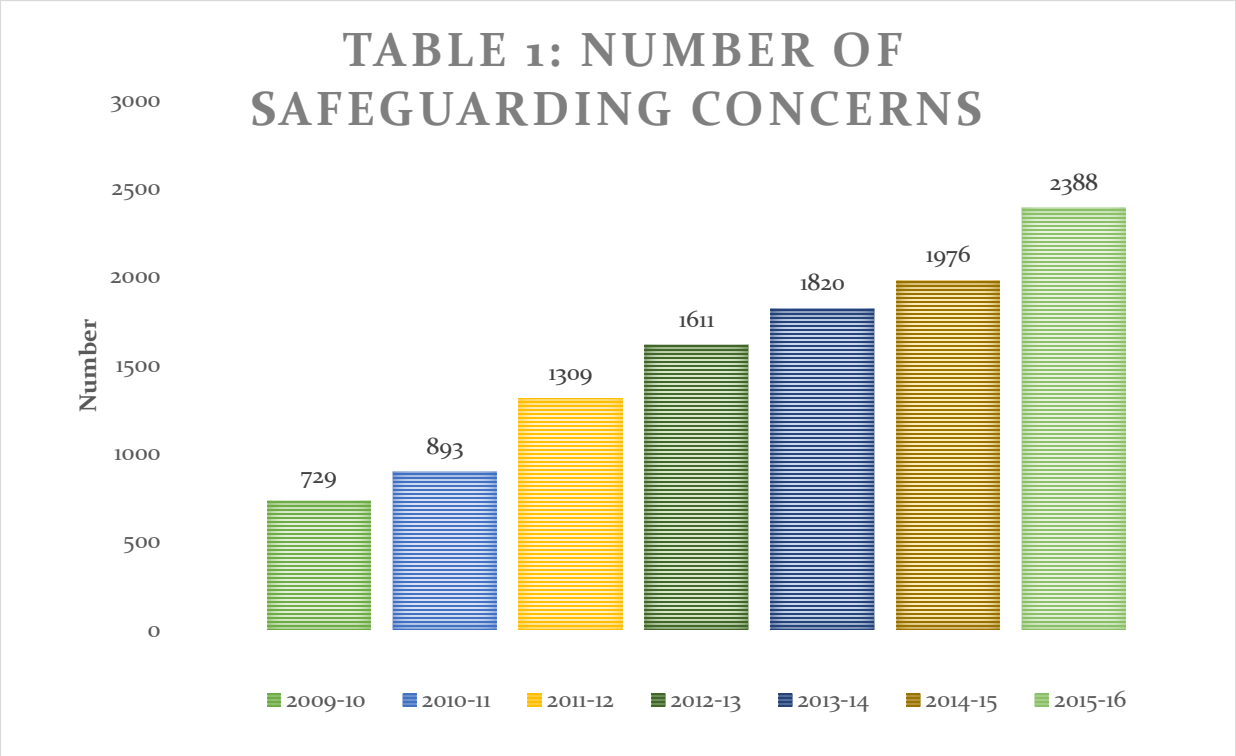


Table 1 shows how many safeguarding adults concerns were received each year by Lambeth Adult Social Care and South London and Maudsley (SLaM) NHS Foundation Trust, as these are the two organisations which coordinate the responses to safeguarding adults concerns in Lambeth.

The number of concerns reported continues to increase year on year. As well as the ongoing trend of increasing awareness around adult abuse and neglect, the Care Act 2014 coming in to force on 1st April 2015 broadened the range of issues that are now seen as a safeguarding concern including modern slavery and self-neglect. The population of Lambeth was estimated to have grown by 1.2% over this period (Source: ONS), accounting for some of the growth.

Overall, almost 60% of safeguarding concerns reported led to a safeguarding enquiry.

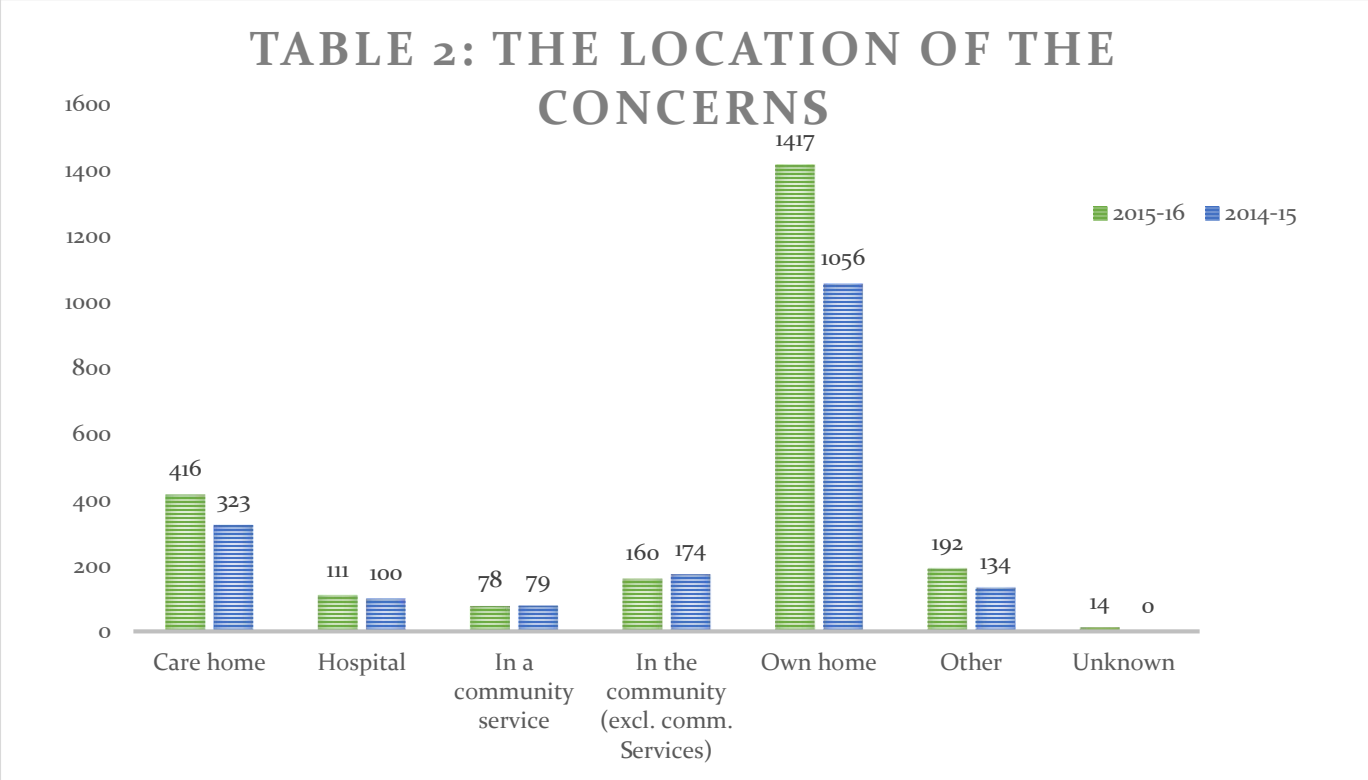
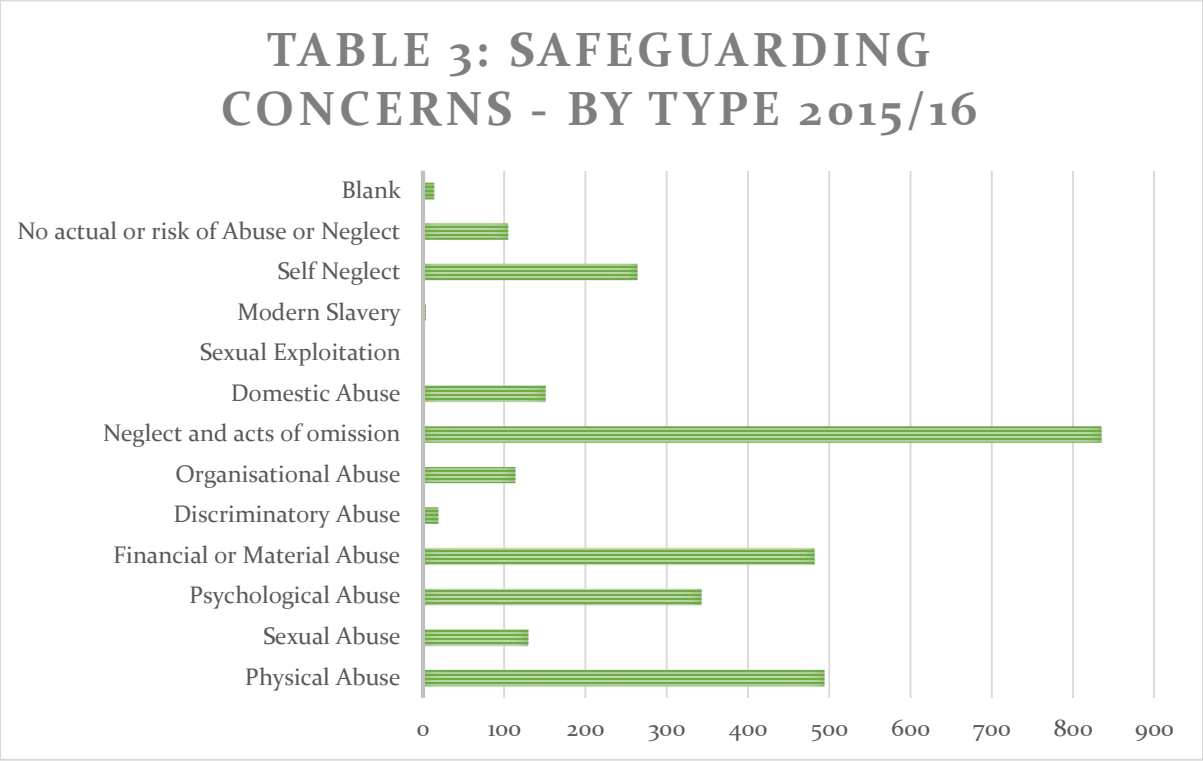


Table 2 shows the location of where safeguarding concerns about abuse or neglect are reported to be happening. The most common location of where safeguarding concerns occur continues to be within individuals' own homes and care homes. This is consistent with the national picture which showed 43 per cent of concerns occurred in the home of the adult at risk and 36 per cent in a care home.

In 2015-16 Lambeth Safeguarding Adults Board adjusted its collection around location of concerns so that more specific information could be obtained. This included whether 'own home' meant the concerns related to council housing, extra care housing or hostels- the difference meaning that the LSAB would seek to understand what additional support is required in these areas to safeguard adults at risk.

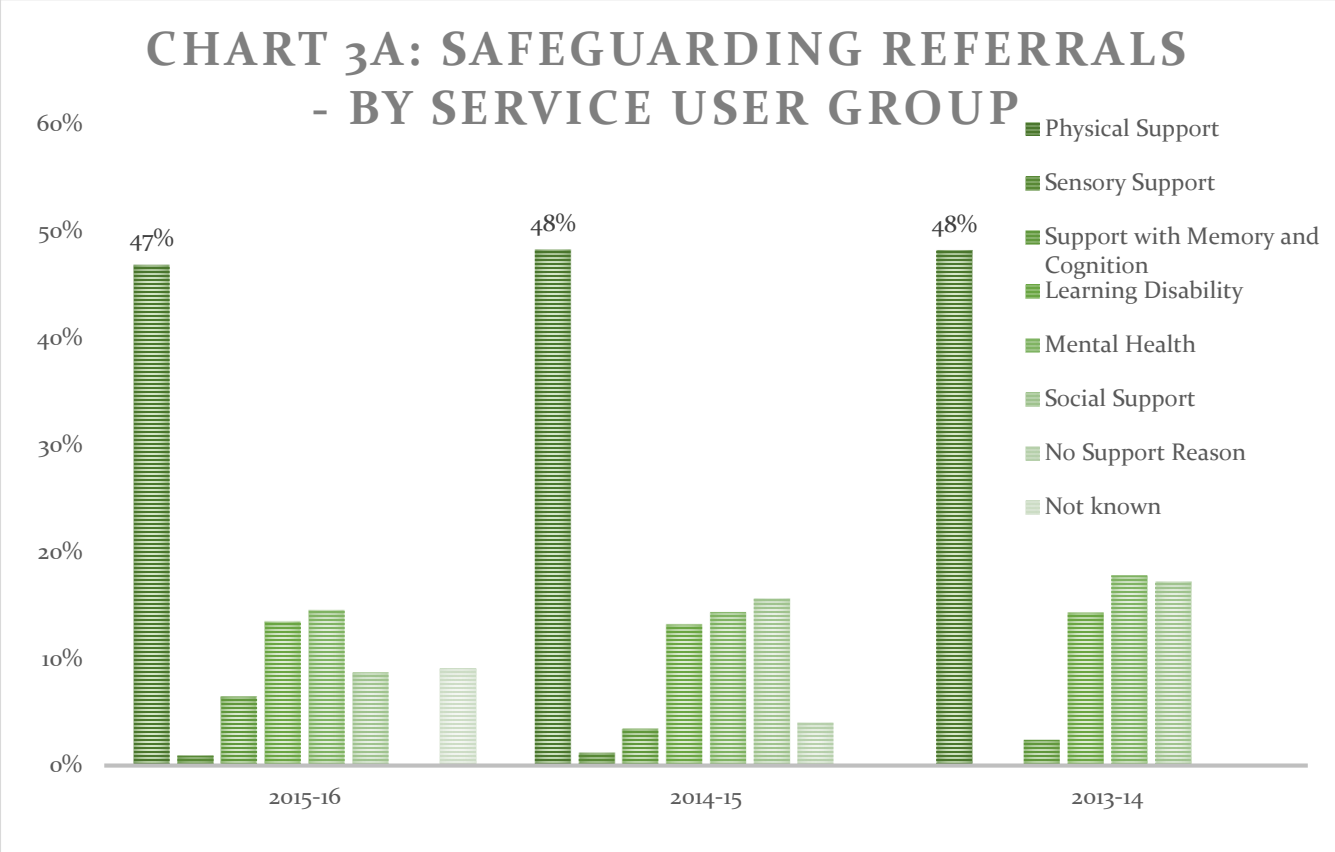
By understanding where these issues occur, the Board can plan targeted action to address them.



The most common issues in 2015/16 were neglect (30% of all concerns), physical abuse (17%) and financial abuse (15%). The proportions of organisational abuse, sexual abuse and discriminatory abuse have remained similar year on year. This is similar to the national picture.

Self-neglect formed 8% of the concerns and is a new area of safeguarding work under the new Care Act. Prior to the Care Act, these types of concerns were dealt with outside the safeguarding arena. The revised Care Act guidance suggests that not all concerns of self-neglect should fall under safeguarding.

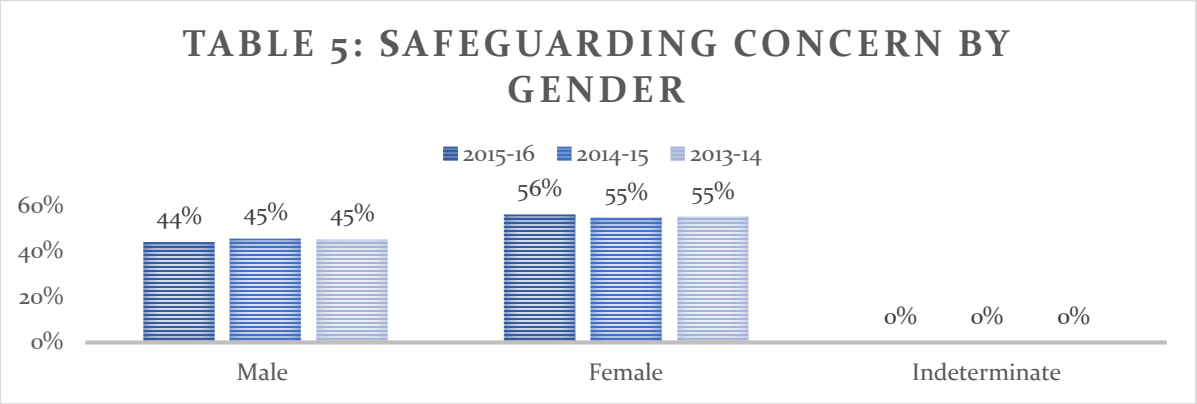
Another new area under the Care Act is Modern Slavery and to date, there have been three concerns raised in relation to this although none of these concerns required an enquiry under adult safeguarding. There is a Modern Slavery Act 2015 which covers cases where an individual is not considered an 'adult at risk' under section 42 of the Care Act 2014.



The proportion of safeguarding enquiries by service user group broadly mirrors the pattern of people using adult social care services. Most people using adult social care services in Lambeth do so in connection with their physical health needs, and it is within this group that we see the most safeguarding adults concerns.

The number of safeguarding concerns relating to people with mental health needs has increased by 10% and this likely reflects the work done by SLaM to improve their safeguarding responses.

There has been a 39% increase in concerns for those who need support with memory and cognition. This is likely due to self-neglect as a category being introduced under adult safeguarding. This may also reflect the work done by Integrated Commissioning Services and Healthwatch in Lambeth who have been conducting inspection visits and working to improve provider concerns procedures.



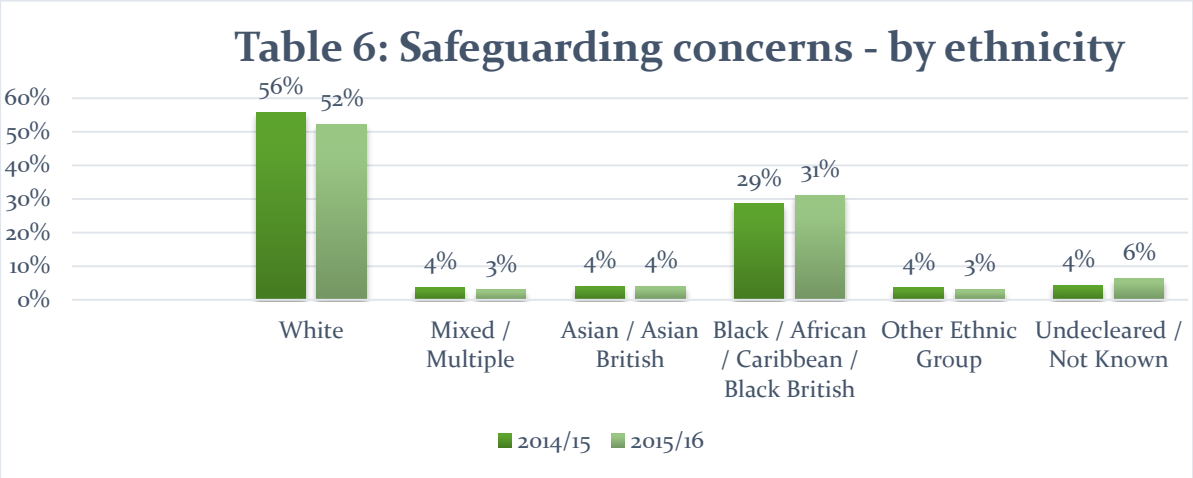


Table 5 shows the numbers of concerns of individuals broken down by gender with comparisons over the last three years. Females do continue to account for 56 per cent (average) of the concerns which is lower than the national average at 60%. The LSAB will continue to challenge the myths around gender and abuse particularly in domestic abuse where men are at risk of not getting the support they need.

Table 6 reflects ethnicity by concerns with the White ethnic group accounting for 52% which is lower than the national average. Black/African/Caribbean/Black British accounted for 31% and Asian British accounted for 4%, both of which are higher than the national average but reflect the ethnic composition of the Lambeth population.

8.2 Lambeth's Safeguarding Adult's Board Achievements in 2014-15

This is what the LSAB achieved against its strategy plan:

Care Act 2014 compliance

A Care Act 2014 compliance audit was prepared by the local authority to support partners to be Care Act compliant.

All partners are now Care Act 2014 complaint with regards to their safeguarding adults' arrangements.

Mental Capacity Task & Finish Group

This group was tasked with exploring methods of seeking assurances from partner agencies in respect of MCA implementation.

An implementation plan, based on the NHS London Toolkit has now been formulated.

Accountability & Assurance

All Board members provided information to the board about how their organisations were responding to all areas of adult safeguarding.

This allowed for scrutiny of their effectiveness and for partners to hold one another to account.

Making Safeguarding Personal (MSP) agenda

Under this agenda, the safeguarding process changed to focus on achieving what the person says they want. Systems were therefore re-designed to facilitate MSP implementation. This enabled a data source for measuring safeguarding outcomes.

The LSAB has been able to monitor safeguarding outcomes and either received assurance of these or was able to identify and address

Well-established executive sub-group

The Performance and Delivery Executive Committee (PaDEC) as a sub group of the Board has shown a commitment to joint working in delivering the multi-agency safeguarding adults agenda and advising the Board accordingly.

Important single agency and partnership issues were discussed and the way forward agreed.

8.3 Board Partners' Achievements in improving Adult Safeguarding 2015-16

- **NHS England**
  - NHS England conducted a 'Deep Dive' into CCG compliance with the NHS Safeguarding Accountability and Assurance Framework. The feedback was very positive, with most criteria being 'assured as good'.
  - Identified actions included formulation of specific CCG policies, as well as strengthening assurance processes from independent providers.
- **Lambeth CCG**
  - Lambeth CCG appointed a designated adult safeguarding nurse post which commenced early 2016. The Designated Nurse also acts as the CCG Mental Capacity Act Lead.
  - The role provides leadership, support and advice for both CCG and commissioned services and has an integrated management structure alongside Lambeth Council Safeguarding and Quality Team.
  - This has proved beneficial in gaining a more rounded view of local and national safeguarding themes, whilst promoting good collaboration between health and social care.
- **Lambeth Housing**
  - The housing sector in Lambeth has focussed on improving their understanding of adult safeguarding and its role and responsibilities.
  - The Council's housing services and local social landlords undertook self-audits regarding safeguarding adults, and identified actions to address the gaps identified.
  - Specific training was developed and has been rolled out for all Housing providers which covers all essential knowledge around Adult Safeguarding, Domestic Abuse and Prevent.
- **Guys & St. Thomas' NHS Trust**
  - There have been continuous efforts throughout the year to raise staff awareness of safeguarding adults and children.
  - One example is that all staff were issued with an adult safeguarding pocket guide as an aide memoir to refer to when faced with a safeguarding situation. This was commended by the CQC at their recent inspection.
  - The Trust has maintained its safeguarding adults/MCA/DoLS training compliance of 85%.

- **Kings College Hospital NHS Foundation Trust**

  - Kings introduced a new database for the team. This has more flexibility and allows the team to run reports and access data from any site and pc within the trust.
  - Reviewed and restructured the team to include an LD Nurse specialist who was appointed February 2016. This is a more senior post to provide clinical and strategic direction.
  - Kings completed a mortality review for LD for 2014 -2015 which considered application of Mental Capacity Act. This will now be an annual audit
  - Re-established the Trusts internal Safeguarding Adults, Learning Disabilities and Mental Capacity Act Group with representatives from each directorate to improve flow of information and assurance. The representatives provide updates re ongoing cases and training compliance.

- **South London & Maudsley NHS Foundation Trust (SLaM)**

SLaM undertook a number of activities within 2015/16 including:

  - A Trust wide audit of safeguarding adults' knowledge and record keeping

  - Review of Trust mandatory Level 1 and Level 2 safeguarding adults training – to reflect Care Act changes

  - Significant work undertaken to build additional Safeguarding Adults fields into the Trust Datix Incident Reporting System in order to provide safeguarding data by CAG and Borough

- **Lambeth Adult Social Care (ASC)**

  - Lambeth ASC amended their data recording systems to ensure all statutory and other adult safeguarding information could be captured as of 1st April 2015. This has allowed for Care Act compliant data to be produced, monitored and reported on to the LSAB.

  - Lambeth ASC commenced monthly Safeguarding Good Practice Forums to provide front line practitioners and managers with updates from the LSAB and relevant training to build confidence and skills under the new remit of adult safeguarding within the Care Act

  - Lambeth's Learning and Development Team has developed a more robust training monitoring system to ensure that all front line staff complete the required mandatory training around Adult safeguarding and other relevant areas such as Mental Capacity training

  - Lambeth commissioned RiPFA to conduct an external evaluation of how effective ASC has implemented Making Safeguarding Personal (see page 17 for these findings).

9. Making Safeguarding Personal: *An evaluation of Lambeth's progress*

research in practice for adults

In 2015-16, LB Lambeth asked RiPFA to undertake an evaluation of their progress to date in implementing a Making Safeguarding Personal (MSP) approach to safeguarding adults.

Lambeth has undertaken work to change the systems and processes in safeguarding to reflect the approach outlined in the Care Act. This small evaluation aimed to find out how well those changes are working, by speaking to staff.

The findings showed that overall, managers and social worker's perspectives on MSP are relatively aligned. Staff seemed to be acting on the essence of MSP, putting the person at the centre, not focussing on process or timescales, but instead working to ascertain what outcomes the person would like, with assessment of mental capacity (where relevant) central to practice.

The main change mentioned was the paperwork and recording related to safeguarding. This was seen as driving a focus on outcomes and person-centred working, but also in need of some further development.

Advocacy was recognised by both groups as being an essential element of safeguarding under the Care Act, especially in cases of institutional abuse, and working well in Lambeth. Access to advocacy was perceived to be satisfactory, despite high demand.

Acceptance of risk and positive risk taking was mentioned as MSP is leading to a less risk averse way of approaching safeguarding, but this can provide challenges in multiagency working as other agencies', and the public's views on risk do not always correspond to the view advocated by MSP.

Leadership and organisational support within Lambeth was perceived to be good with a strong focus on MSP.

The impact of MSP on people who use safeguarding services was viewed (cautiously) as positive; although challenging to use in situations where outcomes were "unrealistic", constantly change, or involve maintaining relationships with the alleged perpetrator.

In 2016/17 Lambeth Adult Social Care will present to the Board the actions that will be taken in response to the recommendations from this review.

10. Learning from Practice

Section 44 of the Care Act 2014 made it a statutory duty for Safeguarding Adults Board's to carry out what is called a Safeguarding Adults Review (SAR) when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them.

The LSAB commissioned a SAR in 2015/16 and this is still underway. The findings of this SAR will be captured in the Annual Report next year.

10.1 A case presented to the Board for multi-agency learning

The LSAPB's executive sub-group, PAQ, has introduced a process for adult safeguarding enquiry case studies to be presented at its meetings, in order promote examples of good practice or to reflect on cases which have raised issues about multi-agency partnership working and to highlight learnings.

The below case was presented as an example of good practice

Details of safeguarding concern:

Allegation of physical abuse on two occasions by security staff whilst Client was an inpatient at a hospital. Client was admitted to Hospital following a suicide attempt. Client jumped off a bridge in to the Thames and has sustained severe injuries after which extensive surgery to both legs and lower back was needed.

Client is a profoundly Deaf man with complex mental health issues and it is for this reason that arrangements were made for him to be transferred to a Deaf Unit based at another Hospital. Here, client disclosed to a member of the nursing staff that whilst at the first Hospital he was kicked by security guards and punched twice in the face.

The principal social worker for the Deaf Service met with Client and subsequently forwarded a safeguarding concern to the Hospital and then to Lambeth Social Services.

A professionals' meeting was held and discussion with the client regarding his wishes and outcomes. An independent advocate was offered, and consideration taken for the need of BSL interpreter.

Summary of the adult safeguarding enquiry

- Information gathered from health electronic patients record system clearly showed that the client was never left in attendance of security staff only. Clear evidence that the client was agitated post operation and the level of distress increased to the point that the client had to be sectioned under MH Act.
- An investigation report was prepared by the hospital safeguarding team clearly recording events leading to the incident and actions taken by the ward staff
- A report was prepared by the Head of security for the hospital
- Safeguarding meeting was held in client's own borough (he was not an ordinary resident of Lambeth) so that the client could have access to BSL interpreter that he is familiar with as well as to ensure that he feels more comfortable in a known environment

  Evidence shows that on balance the clinical decision to provide Client D with morphine was necessary due to the level of pain he was in.

The level of restraint used by security staff did not take into consideration the complexity of the client's communication and mental health needs

Outcome of the adult safeguarding enquiry

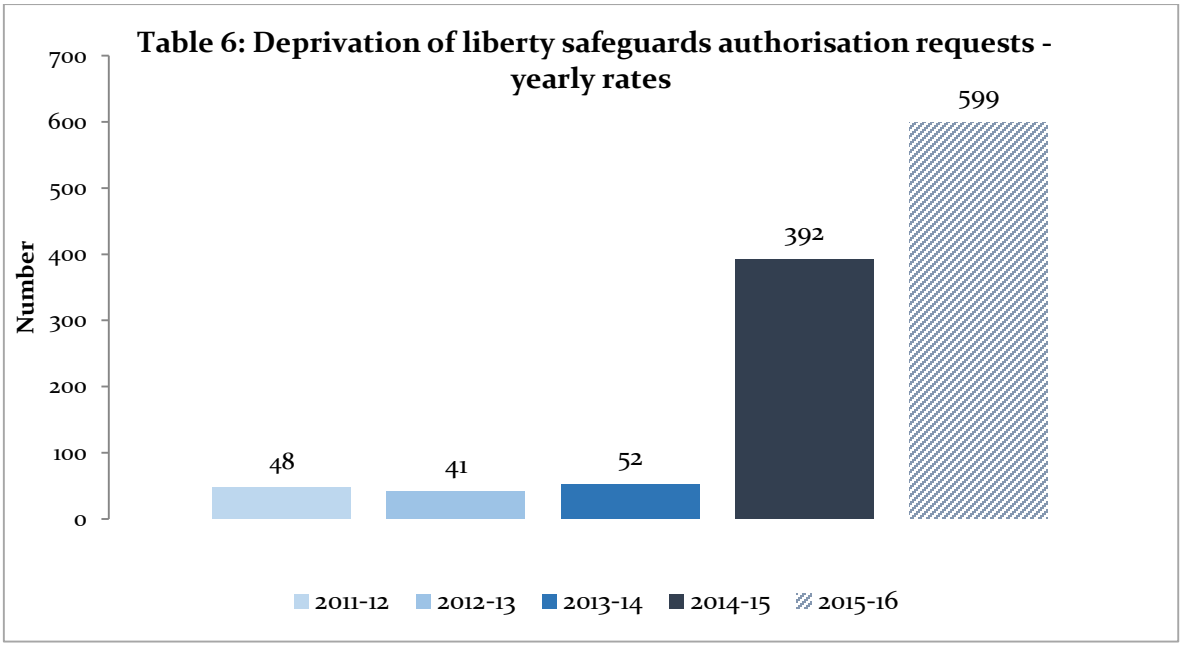
It was concluded that the evidence was unclear either way. However, this investigation has established that the client had been subject to neglect/omission by the Security Guards due to them not having clarity on the level of restraint that took place, position of the client, time spent under restraint and how this was managed.

The Security Staff did not take in to consideration the complexity of client's communication and mental health needs, which in turn impacted on him at the time due to being in a very fragile state of mind due to adverse effect of morphine combined with mental health medication. The client was very pleased that we had included him in the whole process and given him the opportunity to have his say on what happened.

The LSAB will now look at lessons learnt from this case including how information about communication needs of patients is flagged to all staff working with patients. Also, what additional training is required for different staff and how incidents of restraint are recorded?

11. Deprivation of Liberty Safeguards (DoLS)

Lambeth Safeguarding Adults Board has oversight of use of the Mental Capacity Act 2005 (MCA), including its Deprivation of Liberty Safeguards (DoLS). The safeguards are used to protect the rights of people who lack the ability to make certain decisions for themselves and make sure that their freedom is not inappropriately restricted.



The increase in applications for DoLS occurred following the Supreme Court's decision on deprivation of liberty in the Cheshire West case which widened the threshold for what is considered a deprivation of liberty.

In 2015/16 there has been a 50% increase in applications sent to Lambeth as Supervisory Body. The Lambeth DoLS Service has therefore remained under high pressure in an attempt to cope with the number of referrals it is receiving. It has not been able to meet all the statutory timescales within the current level of demand and the Service remains heavily reliant on sourcing independent Best Interest Assessors to carry out this work.

The Lambeth DoLS service has taken a number of steps to try and manage the demand and improve response times including the recruitment of a DoLS manager and DoLS admin officer.

The DoLS process set out in the Mental Capacity Act 2005 can only apply to people in care homes and hospitals. However, in settings in the community e.g. supported living, incapacitated people will often be deprived of their liberty. There has to be an application to the Court of Protection to authorise the deprivation in these cases.

12. The Board's Vision going forward

Constitution

A new constitution was agreed at the Board's Development Day on 15th March 2016. This sets out clearly how the Board is expected to function in order to fulfil its statutory duties. This clearly sets out the following:

- Objectives, Roles and Functions of the Board
- Membership of the Board
- Assurance

One area of importance is our link to and learning alongside Lambeth Safeguarding Children's Board. Independent Chairs of each safeguarding Board will be working collaboratively to ensure areas in common and information is shared where there can be learning across each area.

Strategic plan for 2016-17

The plan was first developed at the Board's Development Day on 15th March 2016. It addresses six main areas:

- Raising public awareness
- Preventing abuse and neglect in health and social care providers
- Embedding "Making Safeguarding Personal"
- Delivering the Deprivation of Liberty Safeguards
- Policies and Procedures